Review of Hospital Financial and Utilization Data Reporting

DECEMBER 1999

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EXECUTIVE SUMMARY

As required by Senate Bill 1973 (Chapter 735, Statutes of 1998), a review of financial and utilization reports filed by hospitals with state government was undertaken. The review focused on opportunities to eliminate collection of unnecessary data, reduce redundant reporting, and consolidate reporting.

The major steps involved in this review included:

- Analysis of current hospital reporting requirements,
- Hospital interviews,
- State agency interviews,
- Data user interviews,
- Review of hospital reporting in Colorado, Florida, and Massachusetts,
- Identification of issues; and
- Development of recommendations.

Based upon the information gathered in this process, a number of recommendations have been made. The major recommendations include:

Recommendations on Report Consolidation

- Integrate the Annual Report of Hospitals into the Hospital Disclosure Report. Eliminate data items on the integrated report that are available in the Hospital Discharge Data Reports.
- Consolidate the Medi-Cal Cost Report with the Hospital Disclosure Report by incorporating the Medi-Cal Cost Report in the OSHPD report. Explore the possibility of including the Medicare Cost Report as part of the consolidation.
- Modify the Hospital Disclosure Report to include the additional information required by the State Controller's Office for district hospitals. Eliminate the separate State Controller's report for these hospitals.

Recommendations on Dissemination of Information

- Enhance the usefulness of Hospital Disclosure Report information by including data files on the Internet that are in the report "page" format. (For example, someone wanting hospital payroll information would be able to obtain only this information.) There also may be alternative data formats that should be considered as well.

- Change the processing cycle of Hospital Disclosure Reports to a calendar year basis and include data from reports in process. Issue updated versions of the data file every three months until all reports are audited.

Recommendations on Reporting Issues

- For reporting purposes only, a uniform definition of eligibility for charity care should be developed. Therefore, if charity care is provided it would be reported as either care for patients that meet the uniform definition or care for patients who do not meet the definition.
- Kaiser Foundation hospitals should be required to include payroll information on the Hospital Disclosure Report for directly assigned nursing staff in Daily Hospital Services cost centers.
- Report total inpatient ancillary charges by type of care and payer on the Hospital Disclosure Report.
- Review and simplify, as needed, the standard units of measure for selected cost centers on the Hospital Disclosure Report.
- Do not modify accounting requirements for normal capitation payment arrangements.

Recommendations on the Role of OSHPD

- Evaluate the OSHPD functional accounting system to determine if it meets the hospitals' accounting and operational needs. Consider eliminating the uniform accounting mandate while maintaining the uniform reporting requirements.
- Discontinue the contract with the Department of Health Services to field audit the Hospital Quarterly Financial and Utilization Report and the Hospital Disclosure Report. Instead consider alternative approaches for reviewing and improving upon the data reported by hospitals.
- OSHPD (as well as the California Health Policy and Data Advisory Commission) should continue to enhance its role and mission as it relates to the use of hospital financial and utilization data in the current health care policy arena.

Other Recommendations

- A number of data reporting changes are recommended, including submission of hospital audited financial statements along with the Hospital Disclosure Report.
- Another data reporting recommendation is to consider participation in the Colorado DATABANK program which would replace the Quarterly Financial and Utilization Reporting with monthly reporting

and include national benchmark data.

- Recommendations on dissemination of data include improving the input of data users in OSHPD decision-making process.

Further information on the recommendations as well as discussion of issues and results of interviews is included in the body of the report.

Part 1
Overview and Recommendations

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BACKGROUND AND OVERVIEW

Legislation

Senate Bill 1973 (Chapter 735, Statutes of 1998) requires the Office of Statewide Health Planning and Development (OSHPD) to contract with a consulting firm to review of the financial and utilization reports filed by hospitals with state government. The bill added Section 128681 to the Health and Safety Code:

> *"The office shall conduct, under contract with a qualified consulting firm, a comprehensive review of the financial and utilization reports that hospitals are required to file with the office and similar reports required by other departments of state governments, as appropriate. The contracting consulting firm shall have a strong commitment to public health and health care issues, and shall demonstrate fiscal management and analytical expertise. The purpose of the review is to identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical. The contracting consulting firm shall evaluate specific reporting requirements, exceptions to and exemptions from the requirements, and areas of duplication or overlap within the requirements. The contracting consulting firm shall consult with a broad range of data users, including, but not limited to consumers, payers, purchasers, providers, employers, employees, and the organizations that represent the data users. It is expected that the review will result in greater efficiency in collecting and disseminating needed hospital information to the public and will reduce hospital costs and administrative burdens associated with reporting the information."*

Request for Proposal

As a result of the legislative mandate, on January 22, 1999, the Office of Statewide Health Planning and Development issued a Request for Proposal (RFP #908-9057). The RFP requested consulting firms to submit proposals concerning the review of hospital financial and utilization data reporting. On April 15, 1999, a notification of intent to award the contract was issued. The selected contractor was the firm of Clark, Lowry & Koortbojian, Inc. Subsequently, the firm contracted with OSHPD and began work on the project in July.

The RFP has specific requirements. The requirements are included in the contract and must be met for the report to be accepted. The key requirements include:

- Review in detail all aspects of the Office's *Accounting and Reporting Manual for California Hospitals*. Review the statutory and regulatory requirements underlying the financial and utilization data programs.
- Review and inventory the data required in the Hospital Annual Disclosure Report, the Hospital Quarterly Financial and Utilization Report, and the Annual Utilization Report of Hospitals, indicating the source or sources of the data items, whether like data items are defined the same, the time period for which the data items are collected, etc.
- Inventory the hospital financial and utilization data collected by other State agencies and compare those data items to the hospital financial, capacity, and utilization data collected by the Office. The inventory will include the data items being collected, the definitions of the data items, the frequency of the collection, the period for which the data are collected, how soon after the reporting period the data are collected, how soon following the collection are the data available, whether the data are collected on paper or electronically, whether the data are required by law and/or regulation, whether or not the data are entered into a computer database, whether the data are electronically available to others, etc.
- Develop a list of users of the Office's financial, capacity, and utilization data, what data items are being used, and how the data are being used. If the data user is a government agency, indicate if the data being used are mandated by law or regulation. Could the government agency continue to perform its functions if the data were no longer collected?

- Recognizing that the Hospital Annual Disclosure Report and the Hospital Quarterly Financial and Utilization Report fulfill different functions, (comprehensive vs. more timely), and further recognizing that the Hospital Annual Disclosure Report and the Annual Utilization Report of Hospitals collect data for different periods of time (hospital fiscal year vs. calendar year) develop a list of duplicated data items from among the three reports collected by the Office. Determine if the items collected on one report could be consolidated into another report, and indicate the consequences of any consolidation.
- Develop a list of data items collected by the Office that are also collected by other State agencies. Even though the titles of the data are the same, are the items defined the same? Are they based on the same time period? Are they collected on paper or in an electronic format? Are the data collected by the other agencies electronically available to the Office? Can the data be easily combined or used in conjunction with data collected by the Office?
- Consult with and survey a broad range of users of the Office's hospital financial and utilization data, including, but not limited to, consumers, payers, purchasers, providers, employers, employees, healthcare consultants, organizations that represent hospitals, and the organizations that represent the data users, to determine their current and future data needs in relation to the data provided by the current Hospital Annual Disclosure Report, Hospital Quarterly Financial and Utilization Report, and the Annual Utilization Report of Hospitals. The contractor shall document the results of the consultations and survey.
- Contact data reporting programs in at least three other states to determine what types of financial and utilization data are being collected and what the data are being used for.
- Develop recommended data reporting changes and the basis for each recommendation. In developing the recommended changes, the consultant will take into consideration and make evident the cost/benefit to the hospitals, data users, and the Office.

Project Team

The project team leader is Stephen C. Clark. The team of consultants involved in the project includes Steve Clark and other staff of Clark, Lowry & Koortbojian, Inc. In addition, Henry W. Zaretsky, Ph.D. , of Henry W. Zaretsky &

Associates, Inc., and Michael Vaida, Ph.D., of Vaida Health Data Consultants, were part of team engaged in the project.

Project Approach

In response to the legislation and the RFP, the approach used by the team consisted of various steps. The major steps are outlined below.

Analysis of Current Hospital Reporting Requirements. A review of the published requirements for hospital reporting was undertaken. In addition, a survey was sent to hospitals asking them to provide copies of reports they submit. The California Healthcare Association, regional hospital associations and hospital constituency groups were instrumental in the selection of hospitals to participate in the project. There was further follow-up with the selected hospitals in telephone interviews. These interviews also solicited information on the effort involved in reporting. A matrix of hospital reporting was prepared to permit an easier comparison of the requirements of the various reports.

Hospital Interviews. The participating hospitals were interviewed to determine their views on a variety of issues. These interviews identified reports submitted by hospitals, and the time and expense involved in reporting. In addition, other financial and utilization reporting issues important to hospitals were identified through these interviews.

State Agency Interviews. A number of state agencies were interviewed to understand their roles in hospital reporting. Some of these agencies require hospitals to submit reports to them while others are data users.

Data User Interviews. A cross section of data users was interviewed to determine how they used hospital data and to identify issues that were important to them.

Review of Other States. Three states (Florida, Massachusetts and Colorado) were selected to compare their hospital reporting requirements to California's. On-site and telephone interviews were conducted to examine their practices and to identify potential opportunities for California.

Issue Identification. Early in the project a number of issues were identified. These were issues involving additional data needs, consolidation of reports, and hospital accounting and reporting practices. As these issues were identified, the project team sought the views of hospitals, state agencies, and data users on the issues.

Development of Recommendations. Once the issues were identified and the views of the various parties obtained, the project team developed the recommendations included in this section. In determining whether there should be a recommendation, the team looked at a number of factors:

- What prompted the identification of this specific issue?
- Is there a consensus among the project team members on making a recommendation?
- Is there a consensus among hospitals, state agencies and data users that were interviewed?
- What are the alternatives to address this issue (including doing nothing)?
- What are the pros and cons associated with the alternatives (including the costs and benefits)?

Throughout the project, the team consulted closely with OSHPD staff to ensure that all the requirements of the legislation and the RFP were being met.

The recommendations should be reviewed in conjunction with the issue papers and other supporting material in order to fully understand the issues.

OSHPD Reports

OSHPD requires three financial and utilization reports to be submitted by hospitals. These reports are mentioned frequently in this report. The terminology used to identify these reports is not always consistent, particularly when hospitals, state agencies and data users were interviewed. Unfortunately, this may lead to some confusion as to which report is being described. The three reports are:

Report	Other Common Names
Hospital Quarterly Financial and Utilization Report	Quarterly Report, Quarterly Disclosure Report
Annual Report of Hospitals	Annual Report, Calendar Year OSHPD Report
Hospital Disclosure Report	Annual Report, Annual Disclosure Report, Annual Hospital Disclosure Report, Financial Disclosure Reports

RECOMMENDATIONS ON REPORT CONSOLIDATION

Consolidation of the Annual Report of Hospitals and the Financial Disclosure Report

Recommendation: Integrate the Annual Report of Hospitals into the Financial Disclosure Report. Eliminate from the consolidated report items that can be obtained from the Hospital Discharge Data. Prepare data files and publications drawn from a subset of the expanded Disclosure Report and the Discharge Data to minimize data loss and access problems. Opinions on planned changes to the Annual Report should be solicited on the OSHPD Web site prior to implementing the consolidation recommended here.

This issue was identified as part of the legislative mandate to "identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical."

All project team members agree on this recommendation.

This recommendation is supported by hospitals and state agencies. Most, but not all users find it acceptable if: (1) OSHPD continues to prepare an Annual Report file for downloading that included data comparable to the current file; (2) data timeliness is not compromised; and (3) demographic data are extracted by OSHPD from the discharge data and input into the OSHPD-created "Annual Report" file. Under this scenario, the only major change that users would realize would be "Annual Report" data available on a hospital fiscal-year basis, rather than a calendar-year basis, as is the case currently. But even assuming OSHPD could implement such a "seamless" change (*i.e.,* prepare a data file nearly identical to the current Annual Report, but derived from data in the Disclosure Report and the Discharge Reports), eliminating the uniform calendar-year reporting period could cause problems for some data users examining several years of data, especially with respect to individual hospitals. These users oppose the consolidation.

Despite the lack of consensus among users, the benefits in our opinion outweigh the drawbacks (see below). However, we do recommend that more user opinions be solicited via a Web site questionnaire.

The recommendation should achieve the following:

- Elimination of the Annual Report. Because the Disclosure Report includes many of the same data items, a slight expansion (less than one page) and modification of the Disclosure Report could eliminate the 12-page Annual Report altogether.
- Elimination of duplicative reporting.
- Elimination of data that are no longer useful. Some Annual Report data is of little current interest. For example, the AR collects detailed information on megavoltage machines (i.e., the age of each machine, days in operation, treatment visits and photon or electron mode). These data would be eliminated.
- More complete hospital and patient profiles. Replacing current Annual Report utilization and demographic data generally collected at one point in time—December 31st—with annual data from the Disclosure Report and Hospital Discharge Data should provide users with better information.

The main drawback of this recommendation is the elimination of data uniformly reported by calendar year or same point in time.

The alternative of merging the Annual Report and the Hospital Quarterly Report was considered and discarded. Merging the Annual Report into the Quarterly Report, while feasible, would accomplish little since the Quarterly Report contains only highly aggregated inpatient volume and capacity data (i.e., total beds and total and long-term patient days and discharges). Virtually all of the Annual Report items will have to be maintained resulting in consolidation in name only.

The interviewed hospitals reported on average five person-days at the ancillary management and technician and general accounting supervisory levels devoted to the Annual Report. This translates in estimated cost savings of $1,200 per hospital. OSHPD could save approximately $10,000 per year, mostly by reducing the need for student assistants performing the Annual Report edits. The permanent staff resources devoted now to the Annual Report could be redirected first toward minimizing the consolidation impact on users; and, later, toward improving the quality and dissemination of the consolidated report.

Implementation of this recommendation will require legislative action, as Section 127285 of the Health and Safety Code mandates the Annual Report of Hospitals. In addition, because the Hospital Disclosure Report is referenced in the regulations, there will also be a regulatory change. The regulations implementing the Health and Safety Code are contained in Title 22, California Code of Regulations, Division 7, Chapter 10, Article 1, Sections 97003-97216.

The table below outlines the recommended approach to consolidation.

Table 1: Consolidation of Annual Utilization Report (UR) into Annual Disclosure Report (DR)

DR Page/ Lines	Description	UR Page/ Section	Description	Recommendation	Comment
1/ 5-30	MISC. INFO. Total beds (licensed, available, staffed), Trauma designation	Nothing comparable		Maintain DR	
1/ 5-55	TYPE OF CONTROL	2/ B	OWNERSHIP TYPE	Substitute UR for DR	More detailed breakout
1/ 5-40	TYPE OF CARE	2/C	PRINCIPAL SERVICE TYPE	Substitute UR for DR	Will lose LT specialty categories, which may not be relevant. But UR has better acute definitions
1/ 60-90	GOVERNMENT PROGRAMS	Nothing comparable, except asks if have Short-Doyle contract		Maintain DR	"'Crippled' Childrens" no longer exists. It is now "California Childrens".
1/ 60-95	24 HR ON PREMISES COVERAGE	Nothing Comparable		Maintain DR	

DR Page/ Lines	Description	UR Page/ Section	Description	Recommendation	Comment
1/ 110-320	MEDICAL STAFF PROFILE	Nothing Comparable		Maintain DR	
2(1) and 2(2)	SERVICES INVENTORY	8,9,10,12	Less detail, most according to bed category	Simplify the service code options to basically identify whether the hospital provides a specific service.	Nine service code options provide excessive detail that leads to inaccurate reporting.
3.1	RELATED HOSPITAL INFORMATION	Nothing comparable		Maintain DR, but for "Type of Business" specify categories	Should minimize open-ended fields
3.2	RELATED HOSPITAL INFORMATION	Nothing comparable		Maintain DR	
3.3	HOSPITAL OWNERS & GOVERNING BOARD MEMBERS	Nothing comparable		Maintain DR, but add occupational categories	Should minimize open-ended fields
3.4	RELATED HOSPITAL INFORMATION	Nothing comparable		Maintain DR, but add codes where possible for management firm, and services provided by management firm.	Should minimize open-ended fields

DR Page/ Lines	Description	UR Page/ Section	Description	Recommendation	Comment
4(1)	PATIENT UTILIZATION STATISTICS licensed, available & staffed beds by category, adult & pediatric patient days & discharges	8	Census, patient days, discharges & intrahospital transfers by bed category	Maintain DR since it is more detailed. Eliminate UR.	Will lose 12/31 Census, and the distinction between Chemical Dependency Recovery in General Acute Care hospitals vs. in Psych beds
4(2)	PATIENT UTILIZATION STATISTICS OUTPATIENT (Mostly)	Nothing comparable, except: CARDIAC CATH (p. 9); SURGICAL SERVICES (p. 11); RADIATION THERAPY (p. 12); and EMERGENCY MEDICAL SVCS (p. 12)		Maintain DR, but add UR cardiac cath. breakdown, UR cardiac surgery breakdown; UR surgical services breakdown; and UR breakdown of Birth and Abortion data (p. 10), excluding nursery days, which are on DR	Will lose inventory of megavoltage machines (p.12). Should consider use of discharge data for cerebral vascular surgery and birth/ abortion data.

DR Page/ Lines	Description	UR Page/ Section	Description	Recommendation	Comment
4.1(1)	PATIENT UTILIZATION STATISTICS BY PAYER	patient days and discharges according to: acute, psych, CDRH, rehab, LTC and other; plus well nursery and purchased inpatient services: all by payer class	Nothing comparable	Maintain DR	
4.1(2)	OUTPATIENT BY PAYER	Broad outpatient categories, keeps ER separate	Nothing comparable	Maintain DR	
	Nothing comparable	2/ A	DATES OF LICENSURE	Maintain UR	
4.1(1) and 4.1(2)	Includes IP & OP hospice data	3/ A	HOSPICE PROGRAM	Maintain DR	Will lose distinction between Distinct Part Nursing Facility-based and General Acute Care-based programs
	Nothing comparable	3/ B	LONG TERM CARE CERTIFICATIONS	Maintain UR	
	Nothing comparable	3/ C	Length of stay intervals for discharged LTC patients	Eliminate, generate from Discharge data	OSHPD will have to make appropriate calculations and merge with UR

DR Page/ Lines	Description	UR Page/ Section	Description	Recommendation	Comment
	Nothing comparable	3/ D	SPECIAL PROGRAMS FOR HOSPITAL-BASED LTC	Maintain UR	
	Nothing comparable	4	LTC INPATIENT UTILIZATION census, admissions and discharges by LTC bed type, discharge place, and major payer	Eliminate in favor of discharge data	The only lost detail will be Intermediate Care-Developmentally Disabled. Perhaps some of these categories could be added to 4(1) on the DR
4(1)/ 105-125	LTC PATIENT DAYS AND DISCHARGES	5/ A	Includes breakdown by sex	Maintain DR, get sex data from discharge reports	
	Nothing comparable	5/ A,B	RACE/ETHNICITY, AGE OF LTC PATIENTS	Eliminate in favor of discharge data	
	Nothing comparable	6/ A,B,C,D	MEDI-CAL SUBACUTE PATIENTS (patient counts, admission source, discharge place, and selected procedures	Eliminate in favor of discharge data	Currently subacute patients are not identified on discharge abstract. If this information is necessary, the discharge abstract should be amended.

DR Page/ Lines	Description	UR Page/ Section	Description	Recommendation	Comment
4(1)/ 25,55,60,110	PSYCHIATRIC UTILIZATION	7/ A	PATIENT CENSUS ACCORDING TO LOCKED AND UNLOCKED UNIT	Not clear how much the "locked" UR category overlaps with the DR "Psych. Intensive Care"	Eliminate UR if enough overlap.
Nothing comparable		7/ B	ACUTE PSYCH PATIENT BY AGE CATEGORY ON DECEMBER 31	Eliminate in favor of Discharge data	Will get annual count as opposed to 12/31
4(1)/ 75	CHEMICAL DEPENDENCY IP UTILIZATION	7/ C	CDR SERVICES PROVIDED IN PSYCH BEDS AND 12/31 CENSUS	Eliminate in favor of DR	Will lose distinction between services provided in psych vs. GAC beds, and 12/31 data
4(1)/ 10	PSYCH IP DAYS BY PAYER	7/ D	ACUTE PSYCH PATIENTS BY PAYER ON 12/31	Maintain DR	Will lose acute psych distinction, and 12/31 data
1/ 75	SHORT-DOYLE PARTICIPATION	7/ E	SHORT-DOYLE PARTICIPATION	Maintain DR	

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation

Recommendation: Consolidate the two reports by incorporating the Medi-Cal cost report into the OSHPD disclosure report. Also, explore the possibility of including the Medicare cost report as part of the consolidation process through a demonstration project with HCFA.

Although we recognize the varying views on which report should be combined into the other, we note the following overriding factors:

1. If HCFA were to agree to include the Medicare cost report as part of the consolidation process, it would require the level of detail contained within the uniform reporting levels required by OSHPD,
2. Data users prefer the level of detail required by OSHPD,
3. If OSHPD were to expand its role with respect to health policy issues, more detailed information will be required than is currently available on the cost report,
4. The OSHPD report is more readily available to the public than the cost report,
5. The technology level required for this type of consolidation is currently available at OSHPD, whereas it does not appear to be available at the Department of Health Services Medi-Cal Audits and Investigations Division,
6. Revisions to the OSHPD accounting and reporting system are only implemented after receiving public input, while the cost report can be changed unilaterally by DHS, and
7. OSHPD has already successfully consolidated the Medi-Cal cost report and OSHPD report related to free-standing long-term care facilities.

This issue was identified as part of the legislative mandate to "identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical." In addition, Section 128730 of the Health and Safety code does require the consolidation of these reports to the extent feasible to minimize the reporting burden on hospitals. At the time the law became effective (January 1, 1986) it was determined that such

consolidation was not feasible. However, the law is still on the books, and it is our opinion that such consolidation is not only feasible, but also practical.

All project team members agree on this recommendation.

All except one hospital supported a consolidation approach. Hospitals were split as to which report should survive. Those that supported the Medi-Cal cost report as the lead report indicated that the level of detail required by OSHPD led to inaccuracies in reporting and excessive accounting and reporting burdens. Those that favored the OSHPD disclosure indicated that the lack of detail in the cost report provided insufficient information to hospitals and policy makers , nor was the report as easily accessible as the OSHPD information.

Hospitals all agreed that the Medi-Cal supplemental worksheets should be eliminated. Most hospitals would like to see California seek a federal waiver to include the Medicare cost report in the consolidation process. All agreed that consolidation of some sort was possible and made sense. The Department of Health Services (DHS) raised numerous issues that would have to be addressed by either approach; however, it was not completely opposed to exploring the concept. OSHPD supported the concept of this consolidation, and indicated that it had the technical capability and expertise required for implementation. Data users were not opposed to the concept as long as data remained accessible to the public.

Implementation of the recommendation will achieve the following:

- Potential elimination of the Medi-Cal supplemental worksheets; most of the data needed for the DHS audit function can be obtained directly from the consolidated report. Other duplicative reporting will also be eliminated.
- The staffing costs associated with the cost report acceptance process and desk-auditing functions could be reassigned to the processing of the consolidated report. Remaining resources could be utilized to research and address public health policy issues. Cost report audit programs could be modified to address new priorities related to the consolidated report. As reimbursement issues decrease in importance, the audit focus can be shifted to specific accounting and reporting issues, such as those related to uncompensated care. Changing the focus of existing staff resources from audits that have no reimbursement impact to both audits and research of data related to public health policy issues will reduce the need to hire additional resources for these new priorities.

- Data users will have easier access to Medi-Cal specific information. Currently the Medi-Cal cost reports are only available through the Public Records Act, while the OSHPD disclosure reports are available upon request. Additionally, Medi-Cal cost reports are maintained as paper files while OSHPD disclosure reports are available in electronic formats which are much easier to retrieve.
- Hospitals will be able to reduce their reporting requirements to the State of California. The additional time to convert the Medicare cost report information to meet the Medi-Cal reporting requirements is 5 to 20 hours, with an additional 10 to 15 hours for the Medi-Cal supplemental forms.
- If HCFA supports a demonstration project to include the Medicare cost report as part of the consolidated report, hospitals will significantly reduce the resources currently required to comply with both state and national reporting requirements. Hospitals have estimated three to five months of staff time are involved in both the cost report preparation and subsequent audit.
- A consolidated report that can be submitted electronically, as currently required by OSHPD, will eliminate the need for a hard copy report as currently required by DHS. This will save resources that are currently utilized to enter data.
- Hospitals and data users will have input into changes and modifications to the accounting and reporting system as currently required with the OSHPD disclosure reporting process. This is unlike the current system with the Medi-Cal cost reporting forms, where unilateral changes can be implemented retroactively at the close of a reporting year. Also, the hospital reporting needs for DHS will not be contingent upon the needs of a Medicare program that no longer resembles the Medi-Cal program.

There are no drawbacks to this recommendation if the needs of OSHPD, DHS, state health policy makers and data users can be met through this consolidated report.

There will be costs associated with the design, development and implementation of the consolidated report and reporting requirements. In addition, there will be costs associated with reorganizing OSHPD and DHS to more efficiently carry out this project. We are estimating a one-time cost to the state of approximately $250,000-$500,000. There will also be cost savings to the state of approximately $150,000 annually that would result from the discontinuation of the field audit contract between OSHPD and DHS for hospital reports. Since the consolidation

would involve all aspects related to the Medi-Cal cost report and OSHPD report, over and above the reporting component, the auditing function of the report would be merged. Other savings may be possible to achieve through consolidation by achieving staffing efficiencies; however, the objective would be to redirect existing staffing resources to meet new health policy objectives.

Implementation of this recommendation will require administrative, regulatory and legislative changes. Although the legislation for such consolidation already exists in Section 128730 of the Health and Safety Code, other existing regulations and legislation may need to be modified to reflect all the specific changes that need to be made. Regarding the OSHPD disclosure reporting requirements, these are included in the California Health and Safety Code, Division 107, Part 5, Chapter 1, Sections 128675, 128680, 128685, 128690, 128695, 128700, 128705, 128710, 128730, 128735, 128740, 128745, 128750, 128755, 128760, 128765, 128770, 128780, 128782, 128785, 128790, 128795, 128800, 128805 and 128810. The regulations implementing the Health and Safety Code are contained in Title 22, California Code of Regulations, Division 7, Chapter 10, Article 1, Sections 97003-97216. All or part of these sections may need to be modified depending upon the specific changes being implemented. Regarding the Medi-Cal cost reporting requirements, Welfare and Institution Code, Division 9, Part 3, Chapter 7, Sections 14170-14178 may need to be modified depending upon the specific changes that are being made. In addition, the Department of Health Services would likely have to modify the Title XIX State Plan and secure approval from the federal Health Care Financing Administration (HCFA).

State Controllers Report/OSHPD Annual Disclosure Report Consolidation

Recommendation*:* Modify the OSHPD annual disclosure report and desk audit process to collect the information required by the State Controller's Office for healthcare district hospitals that report directly to the State Controller's Office. OSHPD should provide the necessary desk audited information. We do not recommend any change for county hospitals because they are only one component of total county reporting requirement.

This issue falls under the legislative mandate to "identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different department, and to consolidate reports wherever practical."

All project team members agree on this recommendation.

This recommendation will only impact district hospitals directly, and county hospitals indirectly. District hospitals supported the consolidation with the OSHPD annual disclosure report because it would reduce the burden of reporting the same basic information to two separate state agencies. It would also eliminate the conflicting due dates. Although the applicable Government Code section related to the State Controller's Report was modified to match that of OSHPD, it did not take into account the extensions frequently allowed by OSHPD. County hospitals report as part of the total county reporting obligation and would not likely benefit from any consolidation. The State Controller's Office did not oppose exploring this option so long as their data publication requirements could be met. OSHPD staff also supported the concept and did not think that any significant resources would be required from them.

Implementation of the recommendation will achieve the following:

- District hospitals will be able to reduce their reporting requirements and eliminate conflicting due dates for the same information.
- As long as OSHPD includes the State Controller's Office report information as part of its electronic file, hospitals will no longer have to submit the information in hard copy, nor will it have to be reviewed manually.
- The State Controller's Office will be able to reassign staff currently assigned to the District Hospital report reviews to other local government agency report reviews. The desk review would become part of OSHPD's existing desk review.

There are no drawbacks to this recommendation as long as OSHPD can implement the changes to their report and desk audit process at a minimal cost.

The minimal cost savings to the State Controller's Office should be offset by the minimal costs to OSHPD. Hospitals will achieve savings of approximately $600 per hospital per year. This is based upon an estimated two and one-half person days at the ancillary management and technician and general accounting supervisory levels devoted to the preparation of the report.

Implementation of this recommendation will require administrative, regulatory and legislative changes for the State Controller. Government Code Section 53891 requires the completion of the Annual Report of Financial Transactions of Special Districts for all California "local agencies." Local agencies are defined as any city, county, any district, and any community redevelopment agency required to furnish financial reports pursuant to Section 12463.1 or 12463.3 of the Government Code. Section 53891.1 modifies the reporting for hospital districts by allowing them to replace the report of all financial transactions, with the specific report pages from the OSHPD annual disclosure report. These are then supplemented with detailed balance sheet related information specified in Sections 53892 and 53892.2 of the Government Code, and year-end audited financial statements. These Government Code sections will have to be modified to allow for the District Hospital reporting function to be transferred to OSHPD.

OSHPD will have to make changes by revising its annual disclosure report forms and accounting and reporting manual to accommodate the additional information required of District Hospitals by the State Controller's Office. Also, changes to the computer software packages will have to be made, and processes put in place to allow for the information to be transferred to the State Controller's Office.

OSHPD's implementation of this recommendation will require administrative, regulatory and legislative changes. Although the legislation for such consolidation already exists in Section 128730 of the Health and Safety Code, other existing regulations and legislation may need to be modified to reflect the detailed changes that need to be made. Regarding the OSHPD disclosure reporting requirements, these are included in the California Health and Safety Code, Division 107, Part 5, Chapter 1, Sections 128675, 128680, 128685, 128690, 128695, 128700, 128705, 128710, 128,730, 128735, 128740, 128745, 128750, 128755, 128760, 128765, 128770, 128780, 128782, 128785, 128790, 128795, 128800, 128805 and 128810. The regulations implementing the Health and Safety Code are contained in Title 22, California Code of Regulations, Division 7, Chapter 10,

Article 1, Sections 97003-97216. All or part of these sections may need to be modified depending upon the specific changes being implemented.

RECOMMENDATIONS ON DISSEMINATION OF INFORMATION

Availability of Hospital Disclosure Data on the Internet

Recommendation: Make the "page format" disclosure data available on the Internet. (Page format disclosure files are computer files corresponding to a single page of the Disclosure Report.) Continue to explore the conversion of data to the SAS format (a commonly used statistical analysis tool), and possibly other popular formats.

The recommendation addresses at least in part a larger issue identified in interviews with data users: the need to improve access to the disclosure data.

All project team members agree on this recommendation.

While users expressed general satisfaction with the current disclosure data subset available on the Internet many wish to have easy access to the other parts of the data. There is also some frustration with the difficulty of processing the data. The solution specifically suggested was to make the data available on Internet in SAS format.

The recommendation should achieve the following:

- Instant and selective access to data. Some users only need selected pages of the disclosure report. Since the "page format" files could be compressed to relatively small sizes, selected pages should be easy to download.
- Virtual elimination of the need for extra computer programming to access the data, at least for those users conversant with SAS—generally the research community—if the "page format" files could be converted to SAS. Eventual conversion of the data to business software formats would be a convenience for other users.

- Wider dissemination of the disclosure data; "net surfers" who may not want to purchase the entire data set will be able to download specific pages of the report.

The costs associated with this proposal should be very minor if the "page format" files are posted on Internet in the current format. It is our understanding that OSHPD is already exploring the conversion to SAS. If the conversion is implemented as a separate project, the costs of posting the converted files on the OSHPD web site will also be minor. Some users who currently purchase the data from OSHPD may switch to free downloads of selected pages. An undetermined loss of revenue could result.

Release of Annual Hospital Disclosure Data.

Recommendation: Change the release cycle to fiscal periods ending between January 1 and December 31 of a given calendar year. Include all reports, whether or not they have been desk audited. Ensure easy identification of audited and unaudited reports. Continue to update the data file and issue updated versions every three months until all reports in the file are desk audited. Information on the percentage of desk-audited reports by fiscal ending period should be made available at the time of each update.

The issue was identified because of the significant lag between data submission and the OSHPD release of the Annual Hospital Disclosure computer files.

All project team members agree on this recommendation.

Hospitals, state agencies and data users were not asked for an opinion on this specific recommendation. However, the timeliness of data emerged as a major concern. Under the current approach the release cycle consists of fiscal periods ending between June 30 of one year and June 29 of the following year. By the time data are released, the June 30 reports are approximately two years old. Under this proposal the June 30 reports will be available 15 months after the end of the reporting period.

This recommendation will achieve the following:

- It will give the user a choice between timely data that may contain some unaudited reports versus waiting for 100 percent audited data. Judging from the audited/unaudited ratio in the 1998 "Hospital Annual Financial Data" Internet file, which is based on the cycle suggested above, approximately two thirds of reports will be audited in time for the first release.
- The largest block of reports, those from facilities with fiscal periods ending June 30 which represent 40 percent of all hospitals, would be available approximately nine months sooner than under the current approach. Moreover, practically all of the June 30 reports will be audited.

Some potential drawbacks are:

- Earlier versions will contain some unaudited reports without the cost allocation pages. If detailed information on the percentage of unaudited reports is made available prior to purchase, and depending on their purpose, users can determine whether to wait for more complete versions.

- Introduction of a different release cycle may cause discontinuity in the historical data bases accumulated by users. Users themselves can address this problem by combining reports from different cycles.
- Users purchasing an early version will have to double their expense if they want to acquire the final audited update. This could be addressed by giving discounts to purchasers of multiple updates, if necessary.

The costs associated with this proposal should be relatively minor, as no major changes in the processing of the data are necessary. However, there may be OSHPD workload implications that should be carefully examined.

It should be noted that currently OSHPD makes available the type of early disclosure files envisioned here *on request*. The on request policy could be an alternative to the quarterly updates suggested here, provided that the availability of early, albeit not completely audited, data is widely publicized. Price restructuring for multiple versions of the same data should also be considered.

RECOMMENDATIONS ON REPORTING ISSUES

Uniform Reporting of Bad Debts and Charity

Recommendation: A uniform definition of charity care should be implemented for reporting purposes only. It should provide a measure of the services provided to economically distressed or disadvantaged patients based on the patient's income measured by a specified percentage of the federal poverty guidelines. A specific field should be added to the Hospital Disclosure and Quarterly Reports for this item. Additional fields should be added enabling individual hospitals to record additional charity care based on their own policies. This recommendation should not be interpreted as establishing any kind of charity care mandate; the only issue is to achieve comparable data for consistent reporting. Because this recommendation could, however, have implications for various indigent care funding streams (i.e., through future public policy initiatives), we recommend a thorough Health and Human Services Agency review prior to implementation.

The issue was identified because of the current lack of uniformity in reporting charity care, and its importance in distributing disproportionate share and tobacco tax funds; another factor was the Attorney General's oversight of non-profit hospital ownership conversions.

All project team members agree on this recommendation.

Hospitals were divided on this issue. Those opposing a uniform definition of charity care pointed to the difficulty of collecting financial documentation from patients, the potential for inappropriate auditing, the potential of misuse by patients and the imposition of a "de facto" standard charity requirement. Hospitals supporting the uniform definition saw it as an appropriate guideline and a way to make charity data comparable across hospitals. Data users who analyze bad debt and charity data perceived the current reporting of those items as lacking uniformity, making any comparative analysis difficult.

Implementation of this recommendation should result in:

- More uniform reporting of charity care, while maintaining hospitals' latitude to establish their own charity policies. At least the following states have adopted uniform charity care definitions: Maine, Massachusetts, New Jersey, Rhode Island, Washington and Florida. While some of these states have implemented uncompensated-care pools or minimum charity requirements, our concern is only with the issue of definition. In California the current reporting of charity is haphazard, varies widely between the Quarterly and Annual Disclosure Reports, and even varies widely within the Annual Disclosure Report as filings are amended by hospitals.
- Charity care data that are comparable across hospitals.
- A uniform charity care definition that will provide a guideline for distinguishing between charity and bad debts. Currently, some hospitals appear to make little, if any, distinction between these two items. According to consumer advocates, there is a difference: a hospital's collection attempts could have a chilling effect on low-income patients, discouraging them from seeking care, or encouraging them to switch to a hospital with different accounting practices. On the other hand, from the hospital's perspective, attempting to collect at least a portion of the bill is good business practice. A uniform definition, with perhaps a sliding scale based on federal poverty percentage, could offer at least an advisory threshold for bad debts. Then, if a hospital elected to define all charity as bad debts, it would knowingly submit itself to public scrutiny.
- Uniform reporting of charity and better distinction between charity and bad debts will provide a more reliable database if an uncompensated care pool were established.

Implementation of this proposal may result in undetermined increased costs to hospitals, as more documentation could be required than under current policies. Relatively minor costs will be incurred by OSHPD to accommodate the proposed reporting changes.

Implementation of this recommendation will require administrative and regulatory changes. Regarding the OSHPD disclosure reporting requirements, these are included in the California Health and Safety Code, Division 107, Part 5, Chapter 1, Sections 128675, 128680, 128685, 128690, 128695, 128700, 128705, 128710, 128,730, 128735, 128740, 128745, 128750, 128755, 128760, 128765, 128770, 128780, 128782, 128785, 128790, 128795, 128800, 128805 and 128810. The regulations implementing the Health and Safety Code are

contained in Title 22, California Code of Regulations, Division 7, Chapter 10, Article 1, Sections 97003-97216. All or part of these sections may need to be modified depending upon the specific changes being implemented.

Because adoption of a uniform charity definition could lead to future public policy affecting a variety of indigent-care funding streams, the Health and Human Services Agency should take the lead on this issue.

Kaiser Foundation Hospitals Reporting

Recommendation: Using the framework of the Disclosure Report, individual Kaiser hospitals should be required to complete certain parts of the detail of direct payroll costs, *i.e.*, wages and hours for Registered Nurses, Licensed Vocational Nurses and Aides and Orderlies. The reporting would be limited to Daily Hospital Services cost centers (Medical/Surgical, Obstetrics, Pediatric, various Intensive Care Units, etc.).

The issue was identified because Kaiser hospitals are not required to, and do not, report detailed cost and revenue information by individual facility. This creates a significant gap in the disclosure database. In particular, detailed payroll information is now necessary, given the recently enacted legislation (AB 394, Chapter 945, Statutes of 1999) requiring the Department of Health Services to promulgate nurse staffing standards.

All project team members agree on this recommendation.

Many data users were concerned about the lack of financial and staffing data for the individual facilities of one of the State's largest hospital systems. From their perspective this recommendation is positive but only a small step; most would like to see full reporting. Kaiser representatives whose input was sought for this report support the recommendation.

The recommendation is expected to:

- Provide complete statewide nurse staffing information for at least daily hospital services.
- Result in an improved database for researchers investigating the link between nursing levels and quality and outcome of hospital care.

We considered two other alternatives.

- Require full reporting of cost and revenue information by individual Kaiser facilities. The major rationale for the Kaiser exclusion is that its hospitals were unique among California hospitals in their provision of care and capitated financing when the Hospital Disclosure legislation was enacted in the 1970's. With more and more hospitals now accepting capitation payments, the reliability of patient revenue assigned to specific cost centers is suspect for these hospitals as well. Costs and utilization statistics, nevertheless, are gathered at the individual hospital level, and there is no reason to believe such data are less reliable for Kaiser hospitals, and could not be included in the Annual Disclosure and Quarterly reporting

systems. After extensive discussions with Kaiser representatives, it appears that the corporate accounting structure does not allow for accurate allocation of costs and revenues among the three Kaiser legal entities (Health Plan, Medical Group and Hospitals). Kaiser facilities may be able at best to comply with the letter of a full reporting requirement, but not provide truly accurate information.

- Require full reporting of the detail of payroll costs, *i.e.* extend it to all categories of employees and include ancillary and support services. This alternative is not considered feasible at this time for the reasons listed above. We hope that OSHPD and Kaiser will continue to explore ways to better integrate the Kaiser hospitals into the Disclosure and Quarterly reporting systems.

Because the information appears to be available, the implementation of this recommendation should have a negligible cost impact on the Kaiser hospitals. No changes are required in the OSHPD systems; small costs may arise from the need of some additional desk auditing.

Identification of Full Patient Care Costs by Type of Care.

Recommendation: Report total inpatient ancillary charges by type of care (general acute, psychiatric and long-term) and payer on the Annual Disclosure Report. Report total inpatient ancillary charges, patient days and discharges by type of care on the Quarterly Report.

The issue was identified because the current reporting system does not allow the identification of full general acute care costs in hospitals that provide psychiatric and/or long-term services.

All project team members agree on this recommendation.

Data users who analyze hospital costs support the recommendation.

Implementation of this recommendation should result in:

- More valid cost comparisons between diverse hospitals.
- The ability to calculate general-acute costs per patient day and per discharge for hospitals providing long-term care or psychiatric services. These cost measures are widely used yet their validity is doubtful when cost differences between various types of care are not taken into account.
- Better benchmarking by hospitals or groups of hospitals that want to compare themselves to industry standards.

The recommendation would require additional reporting by the hospitals. However, most hospitals providing psychiatric and long-term services must maintain this information anyway, as these services are provided in distinct part units.

We considered the more ambitious alternative of requiring allocation of ancillary costs and revenues to each routine cost center. This would have allowed the calculation of full costs and revenues according to a "product line" (*e.g.*, Med/Surg, OB, NICU, Rehabilitation, Psychiatric, Skilled Nursing). The Massachusetts system includes such reporting detail. However, such a requirement may be burdensome to both hospitals and OSHPD. We decided in favor of a more modest proposal.

The costs incurred by hospitals to provide information under this proposal should be minimal. The OSHPD will incur some minor costs associated with system changes and additional desk auditing.

The required changes to the Disclosure Report can be implemented administratively. However, the changes in the Quarterly Report require legislative approval.

Simplify Standard Units of Measure

Recommendation*:* Simplify the OSHPD required standard units of measure on a case-by-case basis. Although this recommendation will not result in significant cost savings for either hospitals or OSHPD, it could lessen the burden of gathering or creating statistics to meet the OSHPD reporting requirements. In addition, it would better achieve uniform reporting for hospital cost and revenue per unit comparisons by reducing the number of statistics subject to interpretation. Although all of the statistics should be evaluated, emphasis should be placed on those related to the following departments: clinic, operating room, anesthesiology, blood bank, all radiology-related departments, MRI, all therapies including respiratory, and all support services whose statistics are not obtained from another area of the disclosure report. Any modifications to the statistics should attempt to provide a measure of resource allocation; however, simplicity and uniformity should be the overriding factors.

The issue was identified because of the current lack of uniformity in the OSHPD accounting and reporting system. The usefulness of the information is jeopardized if data users cannot rely on its accuracy. In addition, all hospitals that were interviewed indicated that many of the standard units of measure were either impractical and/or burdensome to collect, and were subject to numerous interpretations.

All project team members agree on this recommendation.

All hospitals agreed that in many cases the standard units of measure currently being reported are not uniform, due to differences in interpretation by hospitals and difficulties in capturing the required statistics. Most agreed that simplifying the statistics would do little to lessen the accuracy of the data being reported, but it could lessen the hospital burden to maintain and report the data. In many cases it will also improve uniformity. Data users did not indicate any problems regarding the standard units of measure; however, they may not be aware that there are interpretation problems that hinder uniform reporting. The only state agency to comment on the statistics was OSHPD, which agreed with the need to perform a case-by-case analysis. OSHPD stressed the importance of the statistic relating to a measure of resource allocation.

Implementation of the recommendation will achieve the following:

- Result in more uniform and accurate reporting.
- Not jeopardize the accuracy of the current accounting and reporting system.
- Reduce hospital data gathering and reporting burdens associated with the current accounting and reporting system.

The potential drawback to this recommendation is the potential that any of the changed statistics will no longer relate to a measure of resource allocation.

Implementation of this proposal may result in undetermined decreased costs to some hospitals, depending upon whether they would continue to maintain the current statistics for internal management purposes. OSHPD would incur some workload costs to review the statistics and consider changing them. In the past, OSHPD has utilized healthcare specialty organizations in order to assist in reviewing statistics.

This recommendation can be implemented by OSHPD through an update to the standard units of measure in the OSHPD *Accounting and Reporting Manual For California Hospitals, Second Edition*. Title 22, California Code of Regulations, Sections 97003-97216 would have to be modified when the requirements in the manual are changed. Specifically, Section 97018 states that the manual is incorporated into the regulations by reference.

Capitation Accounting Methodology

Recommendation*:* No changes in OSHPD accounting practices are necessary under normal capitation payment arrangements. In these situations capitation payments are part of the hospital's operations and out-of-plan payments need to be made when covered patients have to be treated outside their service area. Examples include an emergency for a covered patient traveling outside of the responsible hospital's service area or a situation in which a service is required that the responsible hospital does not provide. How hospital's account for these our-of-plan cases may be confusing to the data user. Therefore, we recommend that OSHPD provide information on specified accounting and reporting issues, such as capitation accounting, as an informational document that will accompany all data releases. These informational releases should be updated regularly to include other confusing accounting and reporting issues as they arise. Specifically regarding accounting for capitation payments, we also recommend that this issue be added to the OSHPD audit program to ensure uniformity in reporting.

In one circumstance, OSHPD accounting practices for capitation agreements need to be modified: When a hospital receives capitated payments that are significant to its operations, and has established contractual arrangements with out-of-plan hospitals to provide services on their behalf for patients located outside their service area. Where this arrangement occurs the hospital should not record the revenue and expenses associated with these out-of-plan arrangements on the hospital books or OSHPD disclosure report. In essence they are acting as an insurance company and including this data will distort or misrepresent the financial picture of the hospital and the hospital industry. However, if the activity is part of a health system and cannot be separated, then the related costs and revenues should be treated as non-operating.

This issue was identified as part of the legislative mandate that the "contracting consulting firm shall have a strong commitment to public health and health care issues, and shall demonstrate fiscal management and analytical expertise." Under this mandate we reviewed OSHPD accounting practices that may not be consistently followed by hospitals, which led to this recommendation.

All project team members agree on this recommendation.

The hospitals supported the current accounting methodology for capitation agreements. The hospitals interviewed had normal capitation arrangements and tried to provide all of the services needed by the capitated plan members. Two

hospital representatives raised the issue of separating the capitation revenue and expenses from hospital operations. Although we agree with the hospitals regarding normal capitation arrangements, the circumstance noted in our recommendation—in which a hospital is acting as an insurance company—should require revenue and expenses from the insurance line of business to be reported as not related to hospital operations.

Implementation of the recommendation will achieve the following:

- Consistent reporting of normal hospital capitation arrangements.
- Exclusion of the insurance line of business from the hospital and hospital industry reporting.

The only drawback of this recommendation relates to the hospital's and OSHPD's ability to discern the difference between normal and insurance type capitation arrangements.

There will be minimal costs associated with changing the OSHPD manual instructions, amending audit procedures, and modifying the disclosure report to separate the accounting for revenue and expenses related to insurance-type capitation arrangements.

Implementation of this recommendation will require administrative changes to the OSHPD manual instructions.

RECOMMENDATIONS ON THE ROLE OF OSHPD

Uniform Accounting

Recommendation*:* Further analyze and evaluate why OSHPD's functional accounting system does not meet hospital accounting and operational needs. If appropriate, eliminate the uniform accounting mandate and move toward a uniform reporting mandate that will better reflect current hospital practices. OSHPD should still mandate a functional reporting system.

We believe that a uniform chart of accounts and numbering system are not necessary to achieve the level of uniform reporting that currently exists, even if the chart of accounts were to be improved.

Currently hospitals are making numerous reclassifications to bring their accounting into compliance with the OSHPD reporting requirements. If hospitals had uniform accounting systems, reclassifications of amounts would not be necessary. This recommendation would help clarify to data users that the information being reported is uniform even though accounting records across hospitals may differ.

This issue came under the legislative mandate to "identify opportunities to eliminate the collection of data that no longer serve any significant purpose…" and to "result in greater efficiency in collecting and disseminating needed hospital information to the public and will reduce hospital costs and administrative burdens associated with reporting the information."

All project team members agree on this recommendation.

Most hospitals agreed that OSHPD should seek uniform reporting to the best extent possible without requiring uniform accounting. The primary factors in determining what internal reporting systems hospitals use are their operational and management needs. The majority of hospitals indicated that the functional uniform accounting system required by OSHPD did not meet these needs. The larger, more sophisticated hospitals had accounting systems that were able to accommodate both internal and OSHPD needs.

However, most hospitals indicated that reclassifications and estimates were common practices to meet the uniform reporting requirements, because they were unable to adapt the OSHPD uniform requirements to meet their operational needs. Most hospitals indicated that the level of detail required by the OSHPD disclosure report leads to a lack of accurate and uniform reporting. The frequency of reclassifications and estimates indicate the current OSHPD system is a uniform reporting system and not truly a uniform accounting system.

The hospitals stated that OSHPD would be better off establishing guidelines for uniform reclassifications and estimates and initiating on-going educational programs rather than mandating uniform accounting. It should be noted the other three state systems reviewed during this project have uniform reporting systems, not uniform accounting systems. We believe that uniform reporting does not lessen the quality of the data that is being reported, as demonstrated by the uniform reporting required by the Medicare and Medi-Cal cost reports. More stringent enforcement to ensure uniform accounting is not the answer; it only prevents hospitals from obtaining the information they need to operate in a more efficient manner, and is not practical or cost effective.

Implementation of the recommendation will achieve the following:

- Elimination of duplicative accounting system costs at hospitals. The cost savings may be minimal for hospitals with automated accounting systems that report both internal data and OSHPD data without manual intervention. These hospitals will likely continue to use these accounting systems. Also, hospital that do not have the dual systems are already making the reclassifications necessary for uniform reporting and presently do not have a uniform accounting system. Some savings may occur for hospital chains that have interstate accounting systems that require modifications for their California hospitals.
- Understanding by the users of the data that the information is not based upon uniform accounting, but is nonetheless accurate and uniform to the extent feasible. Currently users may believe that OSHPD data are derived through an accounting system that does not contain reclassifications based upon estimates or statistical allocations.

There are no major drawbacks to this recommendation. This recommendation addresses the reality of current accounting practices. Identifying issues that impact the quality of the data being reported and responding appropriately will only strengthen their usefulness. If hospitals deviate from the uniform chart of accounts, those auditing hospital records could be at a disadvantage compared to the current situation.

There will be costs associated with the administrative, regulatory and legislative changes. There will be cost savings to hospitals that may simplify their accounting practices. Both the additional costs and savings are projected to be minimal and are not the focus and purpose of this recommendation.

If after further review and analysis it is determined that the uniform functional accounting system mandate should be eliminated, then the implementation of this recommendation will require administrative, regulatory and legislative changes to the sections of the Health and Safety Code that mandate uniform accounting. These are included in the California Health and Safety Code, Division 107, Part 5, Chapter 1, Sections 128675, 128680, 128685, 128690, 128695, 128700, 128705, 128710, 128,730, 128735, 128740, 128745, 128750, 128755, 128760, 128765, 128770, 128780, 128782, 128785, 128790, 128795, 128800, 128805, and 128810. The regulations implementing the Health and Safety Code are contained in Title 22, California Code of Regulations, Division 7, Chapter 10, Article 1, Sections 97003-97216. All or part of these sections may need to be modified depending upon the specific changes being implemented.

Audit of OSHPD Data

Recommendation*:* OSHPD should discontinue its contract with the Department of Health Services (DHS) to audit the annual and quarterly financial and utilization disclosure report data. Instead, OSHPD should consider various alternatives for reviewing and improving upon the uniform data reported by hospitals. Options include contracting with another state agency or private accounting firm to perform the audits, utilizing current OSHPD desk review staff to perform the audits, creating a field audit team within OSHPD, or using the current funding targeted for audits to provide on-going educational sessions for hospitals to better achieve uniform reporting.

The input that we received from hospitals and OSHPD staff indicated that the OSHPD audit is not a high priority to DHS, and that the audit would be more productive if part of OSHPD's responsibilities. We did not receive any feedback during our interview with the DHS Audits and Investigations staff when we asked for their views on the OSHPD audit function. It is likely that OSHPD staff could be of more assistance to the hospitals as a result of their experience with the OSHPD report, and their objective to provide guidance, in a non-adversarial role. In addition, the audit could be performed according to OSHPD's schedule and needs, and not Medi-Cal's schedules and priorities.

An OSHPD-conducted field audit would provide invaluable experience, training and knowledge for OSHPD's desk audit staff. Also, this activity could be used to identify and evaluate accounting and reporting issues at the hospital level. We do not believe that any of the other auditing options identified above could be as successful in accomplishing these goals and objectives. In addition, we recommend that some of the funding currently designated for the audit function be used for on-going training to assist hospitals in complying with OSHPD uniform accounting and reporting system.

This issue was identified as a result of the interviews that took place with both the hospitals and OSHPD. Hospitals were concerned that they are not receiving adequate guidance on questions and issues that arose during the audit function. Most commented that the audits were not thorough or detail oriented and did not seem to accomplish their objectives. Based upon the comments related to the uniform accounting system issue paper discussed elsewhere in this report, it did not appear to us that the audit was identifying accounting issue problems. To achieve accurate and uniform reporting it is important that issues are identified through the auditing process, and then analyzed by OSHPD as part of the on-going maintenance of the accounting and reporting system.

All project team members agree on this recommendation.

Both the hospitals and OSHPD staff support this recommendation. Since we did not receive any feedback from DHS we do not know if it agrees. The data users were not asked for their input; however, we believe they would support efforts to improve the accuracy of the information reported.

Implementation of the recommendation will achieve the following:

- Provide hospitals with auditors who have a higher level of expertise with the OSHPD accounting and reporting system.
- Improve the technical skills of the OSHPD desk auditing staff by allowing them to gain first-hand experience at the hospital level.
- Establish a mutual working relationship between the hospitals and OSHPD to improve upon the quality of the data being reported.
- Provide OSHPD with the control of the audit process to select the types of hospitals being audited, the auditing schedule and the ability to modify the audit program as often as needed.

We do not see any drawbacks to this recommendation so long as the funding for this activity is allowed to continue.

There should not be any significant costs or savings resulting from this recommendation. The existing funding for the audit function should continue and be used to fund this activity as an internal function. Some of the funding could be diverted for educational activities.

Because we are not recommending that the auditing function be discontinued we do not believe that any regulatory or legislative changes need to be made. Administratively, OSHPD will need to review its existing organization and make modifications as necessary.

Mission of OSHPD

Recommendation*:* OSHPD (as well as the California Health Policy and Data Advisory Commission) should continue to enhance its role and mission as it relates to use of hospital financial and utilization data in the current health care policy arena.

This recommendation resulted from our study of the data reporting system in Massachusetts. As part of the Request for Proposal (RFP), a study of data reporting programs in three different states was required in order to determine if there were any opportunities for California. We believe that the mission statement of the Division of Health Care Finance and Policy (DHCFP) of the Commonwealth of Massachusetts provides further guidance to attaining this objective. Its mission is as follows:

> *"To contribute to the development of policies that improve the delivery and financing of health care by:*
>
> *"Collecting and analyzing data from throughout the health care delivery system;*
>
> *"Disseminating accurate information and analysis on a timely basis;*
>
> *"Facilitating the use of information among health care purchasers, providers, consumers and policy makers; and;*
>
> *"Monitoring free care in the commonwealth through thoughtful administration of the Uncompensated Care Pool."*

OSHPD's current activities are consistent with the first two objectives above as they relate to hospitals and the collection of data. However, we recommend that its role be expanded with respect to objective number three, "Facilitating the use of information among health care purchasers, providers, consumers and policy makers."

The statewide uniform accounting and reporting system was originally established under the California Health Facilities Commission (CHFC). In addition to its role as a data collector, the CHFC focus was on evaluating whether hospital cost increases should be controlled by the State through a rate setting process or budget controls. This led to an adversarial relationship between the provider community and CHFC. CHFC's data collection activities were reassigned to OSHPD, and while its mission is to facilitate the use of the information that is

collected from hospitals, its primary activities with respect to the financial and utilization data have been relatively limited to that of a data bank.

Based on the study in Massachusetts, we believe that much can be gained if OSHPD were to increase its activities regarding the distribution of the data that is collected, and provide the necessary information and research to aid in preserving health care in all communities within California. We believe that this can be done if OSHPD were to facilitate the use of the information it collects by providing research and analysis of the data to all those participating in health care policy deliberations. Providing research that is not only valuable to both the legislature and administration, but valuable to providers and consumers as well will further OSHPD's focus on the preservation of quality health care throughout California.

This issue was identified under the Request for Proposal (RFP) that specifically required a study of data reporting programs in three different states to determine if there were any opportunities for California. We believe the opportunity for California is in better facilitating the distribution of the hospital data that are being collected to serve the health care policy needs of California.

All project team members agree on this recommendation.

Hospitals, state agencies and data users were not asked for their views on this recommendation. The specific goals and objectives that are the outcome of these increased activities, and related work plan, will determine who supports or opposes this recommendations. All three groups should support a plan that assists with, and provides information to those who are focused on preserving quality health care. However, the specific activities related to fulfilling OSHPD's mission must be established and carried out in a way that will not create adversarial relationships. Instead data, research and information presented by OSHPD must be focused on meeting the needs of hospitals, state agencies and data users in achieving a common goal.

Implementation of the recommendation will achieve the following:

- Provide more useful information to health policymakers.
- Provide a service to hospitals in return for the data they provide and the fees they pay.

The only drawback to this recommendation would be to create adversarial relationships between the various health care players if the data being analyzed and distributed are not used in a positive and productive manner.

The costs involved in implementing this recommendation is unknown until the specific goals, objectives and work plan are created. The costs will also change

as the work plan is modified on an on-going basis to address current issues. The costs could be minimized if the savings created by other recommendations in this report are utilized to fund these new activities.

It does not appear that sections of the Health and Safety Code, or its related regulation need to be modified to allow for the expanded responsibilities described in this recommendation. However, even if legislation is not required, OSHPD may want to seek a modification to the Health and Safety Code in order to receive affirmation for a changed role. For example, Health and Safety Code, Division 107, Part 5, Chapter 1, Section 128680 could be modified to prescribe a revised intent of the legislature for this activity.

OTHER RECOMMENDATIONS

Data Reporting

- Modify the Service Inventory page (page 2) of the Annual Disclosure Report to reduce the types of service codes. This report page identifies the various services offered and not offered by each hospital. If a service is available at a hospital the service code indicates how the service is made available. For example, is the service provided on-site or through another facility? Is the service provided at the hospital using hospital personnel or through a contractual arrangement? These, along with other differentiations, are made with nine specific service codes. Confusion over how to report the service code types seems to lead to inconsistencies in reporting between hospitals. In other words, this is a situation where providing too much detail fosters less accurate reporting. Therefore, we are recommending that the service inventory code types be reduced to three: service is not available, service is available at the hospital, and service is available by the hospital through an arrangement with another hospital.
- Collapse obstetrics, alternative birthing center, nursery and labor and delivery into one department when the same management and staff are used for all services. Separating these commingled activities into functional departments is almost impossible and leads to estimates and less accurate reporting. Maintaining separate statistics, such as number of deliveries, obstetric days and nursing days, should be continued. This would allow comparisons between hospitals or within a given hospital over a period of time of total costs or revenues of the alternative birthing center per delivery or per patient day.
- Require hospitals to submit their audited financial statements (balance sheet, income statement, statement of changes in equity and statement of cash flows) along with their annual OSHPD disclosure report. If the year-end audited financial statements are not completed by the time the disclosure report is due, they can be submitted as soon as possible thereafter. If the hospital does not have a year-end CPA audit, it could submit its final year-end internal financial statements. However, a formal modification request should

be required if internal financial statements are to be submitted. Upon request from the data user, provide copies of the audited financial statements when the facsimile disclosure report is purchased. In addition, eliminate the statement of cash flows (page 9) from the required disclosure report pages.

There are differences between hospitals' audited financial statement presentation formats and OSHPD's required reporting formats. Many of the hospitals interviewed indicated that there were issues of accuracy for some of the line items reported on the financial statements, a result of converting information from their financial statements to the OSHPD formats. In particular, the most common financial statement where problems occurred was the Cash Flow Statement.

The notes to the audited financial statements may be extremely useful in understanding a hospital's data. Medicare and Medi-Cal already require these statements, so this would not be a significant additional burden. Also, depending upon whether OSHPD's mission and focus is modified (a separate recommendation in this report), the information contained in the notes to the statements may assist with any analysis being performed.

- There is an inconsistency in the OSHPD accounting and reporting requirements on provision of rehabilitation services. Therefore, we recommend that the functional accounting system requirements take precedence. This requires all rehabilitation-related services, regardless of where the service is provided or who receives the service, to be accounted for in the physical rehabilitation care department (account number 6440). Under current accounting and reporting requirements, if rehabilitation services are provided to a pediatric patient, OSHPD requires the revenues, expenses and statistics to be accounted for and reported in the Pediatric Acute department using account number 6295. Placing rehabilitation services in the Pediatric Acute department is inconsistent with OSHPD's practices, which require functional accounting, not responsibility accounting. A similar inconsistency exists in the area of burn care units. This should also be addressed.

- OSHPD should further evaluate joining the Colorado DATABANK program in lieu of its quarterly reporting. Joining the DATABANK program would provide national benchmarking and trend data rather than the current statewide benchmarking and trend data from quarterly reports. (Thirty states currently participate in the Colorado DATABANK program.) The other significant advantage of DATABANK is that comparative data is available within 35 days of month's end. If the quarterly OSHPD report takes eight hours to prepare and the monthly DATABANK report takes 50 minutes to prepare, hospitals may

save time with monthly reporting. Finally the DATABANK program has proven to be simple and easy for state associations to maintain, although it could also be maintained by a State agency such as OSHPD that already has resources in place. Drawbacks to the DATABANK program would include convincing California hospitals that there is an advantage to monthly reporting and that this will not be an additional reporting burden. All changes to data submitted and report formats must be approved by the Colorado Hospital Association. This limitation on modifications may not be any more restrictive than the current requirement that data contained in the quarterly OSHPD report is required to be changed through legislation. Historical data comparisons would be limited to the amount of back-loaded data that is input into the DATABANK system. This change would require legislative action to eliminate the quarterly report, which is specified in statute. Regulatory changes would also be required.

- The SB 697 Community Benefits Reports filed by not-for-profit hospitals have been generally unstructured. In the long-term, we believe the reports will be more useful for the public and easier for the hospitals to complete if a structure is developed and required as part of the disclosure report process and database. Therefore, we support OSHPD's efforts to examine this issue. Hospitals should be involved in any such effort and care should be taken that reporting requirements don't become unnecessarily burdensome.
- The annual disclosure report should also be used to capture information on charity care. There should be specific questions on hospital charity policies. For example, is the hospital's charity policy based upon federal poverty guidelines? If so, what level of the federal poverty guidelines is used to provide care at no cost to the patient?
- Reporting of Medi-Cal disproportionate share transactions should be clarified to ensure they are being reported consistently. Transfers related to any of the disproportionate share programs and medical education funding should be reported similarly. The release of reports to the data user should include information that tells how this information should be interpreted.
- Modify page 1 (Hospital Description) of the Annual Disclosure Report by adding California Children's Service Neonatal Intensive Care certification level. The choices would be fully certified by CCS at either the intermediate, or community or regional level, or not certified. There is currently no statewide data on CCS certification levels of neonatal intensive care units.

Data Dissemination

- Continue producing the publications based on the Annual Disclosure and Hospital Quarterly reports. A significant number of individuals and organizations continue to purchase the publications even though more and more of the information is available on the Internet. This may represent a segment of the user population that is more comfortable with the print medium. Since sale proceeds cover the cost of production and the level of sales is stable, the publications appear to be a cost-effective means of serving these users.
- Improve input into OSHPD decision-making. First, OSHPD should appoint a committee comprised solely of data users, representing the same constituencies that guided our user interviews (*i.e.,* consumers, employees, researchers, consultants, providers, and purchasers). Second, a short questionnaire should be added to the OSHPD Web Site; for every download, the user should be required to complete the questionnaire. The questionnaire would solicit information on how the data are used, previous problems and recommendations for improvement. The questionnaire results, including comments on the proposed changes, should be summarized by OSHPD, at least annually, and reported on the Web Site. All data users filling out the questionnaire should be placed on a data-user mailing list, and informed of all proposed changes (in case they do not visit the site at the time these proposed changes are announced). Also, when contemplating a reporting change, the Web Site should describe the proposed change and solicit input.
- Post the current-year-to-date and previous-year-to-date Hospital Quarterly data on the Internet (for all quarter ending dates). Currently, these files are made available to purchasers of the quarterly data. The year-to-date files are important those users who have difficulty combining the four quarters correctly. The previous-year-to-date files are useful for improving the accuracy of the historical database, as they incorporate corrections made after the initial release of the data.
- OSHPD should annually compile a library of all published research studies using OSHPD data. Of all hospital data sources used by health services researchers, the OSHPD data (financial, utilization and discharge) may be the most widely used. OSHPD would provide a valuable public service through creating a comprehensive library of all studies using its data. Moreover, such a library would demonstrate to the Legislature, administration, industry and public the value of the OSHPD databases.
- Other Recommended Changes in Data Dissemination:

- Include variable titles, rather than codes, in the Annual Utilization Report file.
- Include area-wide demographic data in Disclosure Report publications and the summary page of the individual Disclosure reports.
- Post a case-mix index file with data obtained from the OSHPD patient discharge data set on the Web site. This would allow users to adjust cost and revenue data obtained from the Disclosure or Quarterly reports to account for hospital patient mix.

Part 2
Reporting Issues

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A SIDE-BY-SIDE COMPARISON OF REQUIRED HOSPITAL REPORTS

Matrix of State Agency Required Hospital Financial/Utilization Reporting

As part of our comprehensive review of the financial and utilization reports that hospitals are required to file with the office and similar reports by other departments of state government, we asked hospitals to submit photocopies of reports they have submitted to state agencies. The majority of the reports are included in the following matrix. This matrix outlines the major reports and was utilized to more easily evaluate common information in the required reports. The minor reports that are not included in the matrix are discussed in the state agency portion of this report.

The review of this matrix is helpful in understanding the reports submitted to state agencies. The matrix also is useful in evaluating the recommendations of combining the Annual Report of Financial Transactions of Special Districts, Annual Utilization Report, and the Medi-Cal Cost Report with the California Hospital Disclosure Report. See separate sections of this report for discussions on these combinations. See the appendix for the examples of these reports.

Tables 1 and 2

State Agency Required Hospital Financial/Utilization Reporting is reflected in two Tables. The first table includes the three OSHPD reports that are discussed throughout this report—Quarterly Financial and Utilization Report, Annual Report of Hospitals, and Annual Hospital Disclosure Report. It also includes the Medi-Cal cost report. The second table includes other Department of Health Services' schedules related to the cost report and the State Controller's report that hospital districts must complete.

Table 1: State Agency Required Hospital Financial/Utilization Reporting

	Quarterly Financial and Utilization Report	Annual Report of Hospitals	Annual Hospital Disclosure Report	Medi-Cal Cost Report HCFA-2552-96
Hospital Descriptive Data	Hospital name, quarter ended, OSHPD number, address, preparer's name and telephone number, CEO name, hospital telephone number, disaster coordinator's telephone number and period reported.	Hospital name, CEO, contact person, dates of licensure, address, certification of accuracy, principle service type, government programs in which you are certified to participate.	Hospital name, OSHPD facility number, CEO, contact person, reporting period, address, certification of accuracy, licensed beds, HAS No., type of control, type of care, government programs, prepaid programs, services with 24 hr coverage.	Hospital name, address, hospital sub-providers identification, period covered.
Financial Information				
Income Statement	Income statement for the quarter being reported.	None	For both current and prior year.	For both current and prior year.
Statement of Changes in Equity	None	None	Separated for restricted and unrestricted funds.	Separated for restricted and unrestricted funds.
Statement of Cash Flows	None	None	For both current and prior year separated for restricted and unrestricted funds.	None
Balance Sheet	Fixed assets net of accumulated depreciation (including construction in progress). Disproportionate share funds transferred to related public entity.	None	For both current and prior year separated for restricted and unrestricted funds. Detailed information on long-term debt. Changes in plant, property and equipment. Changes in equity statement.	Analysis of changes in capital assets. Balance sheet for both current and prior year separated for restricted and unrestricted funds. Statement of changes in fund balances also for current and prior year.
Revenue Data	Patient revenue broken down between inpatient and outpatient by payer group. Total of other operating revenue and nonoperating revenue. Deductions from revenue by payer. Capitated premium revenue. Purchased inpatient service revenue.	None	Patient revenue broken down between inpatient and outpatient by payer group and department. Breakdown of other operating revenue.	Patient revenue broken down between inpatient and outpatient and Medi-Cal and Medicare. Breakdown of other operating revenue.

	Quarterly Financial and Utilization Report	Annual Report of Hospitals	Annual Hospital Disclosure Report	Medi-Cal Cost Report HCFA-2552-96
Total Expenses	Total operating expenses (including physician professional component). Physician professional component expenses. Total capital expenditures (excluding disposal of assets). Purchased inpatient and outpatient service expenses.	None	Expenses by department and type.	Expenses by department broken down between salary and non-salary. Reclassifications and adjustments to expenses as required by Medi-Cal. Related party costs. Directly assigned capital costs.
Physician Expenses	Total physician professional component expenses.	None	Compensation by department and salary verses professional.	Compensation by department, broken down by professional and provider components and compared with RCE limits.
Medical Education Expenses	Teaching allowance and clinical teaching support for U.C. teaching hospitals only.	None	By department: medical education supported by hospital, administrative and general and hospital committees, nursing and paramedical care, intern/residents care, supervision and other.	Data needed for Medicare not Medi-Cal.
Labor Data				
Payroll Hours	None	None	Broken down between productive and non-productive. By department and by type of employee.	Total FTE and interns and residents by hospital components. Paid hours by department.
Contract Labor Hours	None	None	Broken down between registry nursing and other by department.	Broken down between patient care and physician services to the hospital.

	Quarterly Financial and Utilization Report	Annual Report of Hospitals	Annual Hospital Disclosure Report	Medi-Cal Cost Report HCFA-2552-96
Volume Statistics				
Routine Services	Licensed, available and staffed beds in total. Patient discharges, days, and outpatient visits by payer. Purchased inpatient service discharges and days.	Long-term care (LTC) discharges categorized by length of stay. Number of LTC patients in special programs. Source of LTC patient admission and destination at discharge. LTC patient days. LTC swing beds. Number of LTC inpatients at year-end by sex, age and race. Medi-Cal Sub-Acute patient census and admissions, source of patients, discharge destination, patients that require specific procedures. Licensed acute psych, or Psychiatric Health Facility (PHF) beds by type, days by age of patient and payer. Year-end census, annual discharges and patient days by bed classification including breakout Chemical Dependency Recovery Services beds if separate bed category. Cardiac surgery, extra corporeal bypass and cardiac catheterization services by adult, pediatric and total.	HMO contract patient days and outpatient visits. Available and staffed beds by department. Patient days by department and adult, pediatric, Medicare and Medi-Cal. Patient census by department by payer.	Available beds. Patient days and discharges broken down by Medicare, Medi-Cal and total. Observation days.
Ancillary Services	None	Catheterization by type. Birth and abortion data. Radiation therapy service statistics. Emergency medical services visits by acuity. Surgical services by inpatient and outpatients and minutes. Also, number of OR rooms.	Ancillary and other utilization statistics including breakdown by inpatient/outpatient and payer.	Cost to charge ratios calculated from submitted data.
Allocation/Cost Finding Statistics	None	None	Allocation statistics by overhead department.	Allocation statistics by overhead department.

	Quarterly Financial and Utilization Report	Annual Report of Hospitals	Annual Hospital Disclosure Report	Medi-Cal Cost Report HCFA-2552-96
Other Information	None	None	Hospital owners and governing Board including compensation and percentage ownership. Physician ownership disclosure. Management firm disclosure. Medical staff profile: FTEs that are board certified, board eligible, hospital based. Services inventory including setting of service. Related party cost disclosure.	Medicare questions related to disproportionate share, rural referral center, transplants, sole community status, teaching, SNF, other special designations, capital payment method, related party, contracted PT or respiratory, renal costs, allocation statistics, other miscellaneous cost questions.
Who Requires Report	The Office of Statewide Health Planning and Development	The Office of Statewide Health Planning and Development	The Office of Statewide Health Planning and Development	Department of Health Services
Due Dates	45 days after the end of each calendar quarter	February 15th	4 months after FYE	5 months after FYE
Estimated Time Needed to Prepare	Six hours.	Forty-eight hours plus one to two weeks to gather statistical data.	Based upon size of hospital, average report preparation time is 210 hours.	Prepared in conjunction with Medicare cost report. 5-20 hours to modify Medi-Cal submission based upon different requirements and interpretations.
Editing procedure	Desk review, including software edits.	Desk review.	Desk review, including software edits.	Cost report software contains numerous electronic edits; however, these are not used by DHS. Hard copy reports are key entered by DHS. Desk reviews for tentative settlements.
Auditing procedure	None	None	Selected sample of approximately 50 hospitals per year.	Extensive audits by the Department of Health Services, including appeal rights.
Exceptions to filing	13-period provider can request adjustment to period reported. Revenue information is not reported by certain hospitals.	None	Short fiscal year reporting requires less information. Certain hospitals do not complete all parts of the report.	Consolidated hospitals with one general ledger are required to file only one report.

	Quarterly Financial and Utilization Report	Annual Report of Hospitals	Annual Hospital Disclosure Report	Medi-Cal Cost Report HCFA-2552-96
Exemptions from filing	Federal hospitals	Federal hospitals	Federal hospitals	Hospitals with no or minimal Medi-Cal inpatient utilization are not required to report. Hospitals with only psychiatric services and no cost-reimbursed unit are not required to report.

Table 2: State Agency Required Hospital Financial/Utilization Reporting (Continued)

	Audits and Investigations Supplemental Worksheets	County Medical Service Program (CMSP) Schedules	Rate Development Branch Supplemental Schedules	Annual Report of Financial Transactions of Special Districts
Hospital Descriptive Data	Hospital name, Medi-Cal provider numbers, reporting period, certification of accuracy, address, date components certified.	Hospital name, Medi-Cal provider numbers, reporting period, certification of accuracy, address, date components certified.	Hospital name, fiscal year end, certification of accuracy, Medi-Cal provider number, and contract period.	Hospital name, county, mailing address, authorized signature, independent auditor name-address-and phone, report preparer name-address-and phone.
Financial Information				
Income Statement	Submit a copy of financial statements.	None	None	Submit a copy of the financial statements, as well as OSHPD disclosure report pages.
Statement of Changes in Equity	Submit a copy of financial statements.	None	None	Submit a copy of the financial statements, as well as OSHPD disclosure report pages.
Statement of Cash Flows	Submit a copy of financial statements.	None	None	Submit a copy of the financial statements, as well as OSHPD disclosure report pages.
Balance Sheet	Submit a copy of financial statements.	None	None	Breakdown schedules and total property plant and equipment, accumulated depreciation, construction in progress, long-term debt. Purpose of bonds and revenues pledged as additional security. Leases. Appropriations limit schedule. Submit a copy the financial statements, as well as OSHPD disclosure report pages.

	Audits and Investigations Supplemental Worksheets	County Medical Service Program (CMSP) Schedules	Rate Development Branch Supplemental Schedules	Annual Report of Financial Transactions of Special Districts
Revenue Data	Medi-Cal charges by ancillary department broken down between contract and non-contract. From Medi-Cal cost report. Cost to charge ratios from Medi-Cal cost report.	CMSP charges by ancillary department. Cost to charge ratios from Medi-Cal cost report.	Total Medi-Cal inpatient charges.	None
Total Expenses	Inpatient Operating Service costs and hospital-based physician costs from Medi-Cal cost report.	None	Medi-Cal net cost of covered services and hospital-based physician costs. Average per diem costs by inpatient floor. Depreciation, rents and leases, interest, property taxes and license fees, utility, malpractice insurance. Gross operating expenses. Student and physician compensation. Pharmacy non-labor expenses. Breakdown by broad category of operating expenses. Productive salary costs broken down by type of employee.	None
Physician Expenses	Hospital based physician questionnaire	Total payment and charges for hospital based physicians (HBP). CMSP HBP charges.	Physician compensation combined with students.	None
Medical Education Expenses	None	None	None	None
Labor Data				
Payroll Hours	None	None	Productive hours broken down by type of employee, e.g. management, RN, etc.	None
Contract Labor Hours	None	None	None	None

	Audits and Investigations Supplemental Worksheets	County Medical Service Program (CMSP) Schedules	Rate Development Branch Supplemental Schedules	Annual Report of Financial Transactions of Special Districts
Volume Statistics				
Routine Services	Medi-Cal patient days by type. Total and Medi-Cal discharges. Medi-Cal administrative days and per diem rate.	CMSP administrative days and per diem rate. Inpatient days total and CMSP.	Medical Inpatient days by unit. Total hospital discharges and Medi-Cal discharges.	None
Ancillary Services	Federally Qualified Health Center or Rural Health Clinic visits.	None	None	None
Allocation/Cost Finding Statistics	None	None	None	None
Other Information	Medi-Cal Credit Balance report. Medi-Cal and other state funding sources.	None	Medi-Cal Deductibles and Coinsurance.	Members of governing body. Secretary, Mgr/Supt/Chief, attorney, and financial officer.
Who Requires Report	Department of Health Services	Department of Health Services	Department of Health Services	Controller's Office
Due Dates	5 months after fiscal year ends	5 months after fiscal year ends	5 months after fiscal year ends	120 days after fiscal year ends
Estimated Time Needed To Prepare	Three to five hours.	Three to five hours.	Two to five hours.	Approximately 20 hours
Editing Procedure	Included in cost report desk review.	Included in cost report desk review.	Included in cost report desk review.	Desk review.
Auditing Procedure	Included in cost report audit process.	Included in cost report audit process.	Included in cost report audit process.	None
Exceptions To Filing	Consolidated hospitals with one general ledger are required to file only one report.	Consolidated hospitals with one general ledger are required to file only one report.	Consolidated hospitals with one general ledger are required to file only one report.	None
Exemptions From Filing	Hospitals with no or minimal Medi-Cal inpatient utilization are not required to report. Hospitals with only psychiatric services and no cost-reimbursed unit are not required to report.	Hospitals with no CMSP utilization are not required to file.	Hospitals with no or minimal Medi-Cal inpatient utilization are not required to report. Hospitals with only psychiatric services and no cost-reimbursed unit are not required to report. Rural hospitals do not have to file.	None

EXEMPTIONS, EXCEPTIONS AND MODIFICATION TO REPORTING REQUIREMENTS

The OSHPD uniform accounting and reporting system provides for certain exemptions, exceptions and modifications to its requirements. Federal hospitals are exempt from California's accounting and reporting requirements; therefore, they are not included in this discussion. Major exceptions are used sparingly, particularly in the reporting area, so that the uniform reporting is maintained as much as possible.

Following is a general discussion of modifications sought from OSHPD for both accounting and reporting. Next is a discussion of each of the OSHPD reports within the scope of this project. Finally, the exemptions, exceptions and modifications permitted by two other major hospital reporting systems, Medi-Cal Cost Reports and the State Controller's Report, are described.

Modification Requests

Based on OSHPD logs, there were 153 modification requests from 1995 through late July 1999. Of these only six were denied outright. The rest were either granted or not pursued by the hospital. The largest category was for a change in reporting period, and accounted for 66 requests or 43% of the total. Many of these changes were the result of changes in ownership, in which hospitals wished to align fiscal years with those of new owners. The 19 requests for consolidation of facilities for reporting purposes often involved a change of fiscal year as well.

There were also 37 requests for modifications to the standard OSHPD Chart of Accounts. Some of these accounting modifications were for minor variations while others were for a complete waiver of the standard chart of accounts with a cross-reference to the hospital's chart of accounts.

OSHPD Quarterly Financial and Utilization Report

The Quarterly Financial and Utilization Report is due 45 days after the end of the calendar quarter. OSHPD may grant up to a 30-day extension of the due date. There is a $100 a day penalty for each day the report is late. Most hospi-

tals are able to report within the due date. Of the 520 hospitals reporting on the 3/31/98 quarter, only 10 hospitals (2%) were late in reporting. (It appears that one or more of the late hospitals were actually closed.) However, 117 or 23% used one or more extension days beyond the 45 days. Almost all of the remaining hospitals submitted the report within 30 to 45 days of the end of the quarter, with 62 hospitals, 12% of the total, reporting within 30 days of the end of the quarter.

Categories of hospitals with exceptions and modifications to the quarterly reporting include:

KAISER FOUNDATION HOSPITALS – These hospitals report utilization data, capital expenditures, and net assets. They do not report revenue and expense information. However, the Kaiser Foundation Northern and Southern Regions do report expenses on a regional basis.

SHRINERS HOSPITALS – These hospitals report utilization data, expense information, capital expenditures, and net assets. They do not report revenue data.

OSHPD Annual Hospital Disclosure Report

The Annual Hospital Disclosure Report is filed based upon the fiscal year of the hospital. It is due four months after the end of the hospital's fiscal year and extensions of up to 90 days may be granted. Thus, the report could be filed as late as seven months after the fiscal year end. There is a $100 a day penalty for each day beyond the deadline. During the 1997-1998 fiscal year reporting cycle (for fiscal years ending between June 30, 1997, and June 29, 1998), there were a total of 562 hospital reports submitted. Of these, 15 reports, 3% of the total, were late. All but 55 hospitals used one or more extension days. Thus, 90% of hospitals did not file within the first four months after the fiscal year end.

Categories of hospitals with exceptions and modifications to the annual reporting include:

KAISER FOUNDATION HOSPITALS – The reporting by these hospitals varies based upon region. The Southern region completes pages 0 to 4 of the report for each facility (general information and utilization statistics) and provides consolidated financial statements. The Northern region completes various parts of the annual report (pages 0-4 and 15-22), excluding revenue information for each facility, and also provides consolidated financial statements.

SHRINERS HOSPITALS – These hospitals complete pages 0 to 9 of the annual report, which includes general information, utilization statistics and financial statements.

STATE HOSPITALS – These hospitals complete pages 0 to 4 and page 8 of the report (general information, utilization statistics, and profit and loss statement.)

PSYCHIATRIC HEALTH FACILITIES – County-owned facilities complete pages 0 to 4 and page 8 of the report (general information, utilization statistics, and profit and loss statement.) Non-county psychiatric health facilities complete the entire report.

SHORT REPORT PERIODS – If a facility has a short report period due to a change in licensure or fiscal year-end date, OSHPD generally will allow it to complete only pages 0 to 9 (includes general information, utilization statistics and financial statements) of the annual report. Typically this would be for report periods of three months or less. OSHPD prefers using shorter period reporting when a report year changes rather than use a fiscal period greater than 13 months.

Annual Utilization Report of Hospitals

OSHPD's Annual Utilization Report of Hospitals is due 45 days after the end of the calendar year. There is no formal policy concerning extensions. Because this report is used to measure licensed services by geographic region, it is collected by hospital location (site) rather than licensee. This means two hospitals operating under a consolidated license will file two annual utilization reports, but only one annual financial disclosure report.

Unlike the other OSHPD reports, there is no financial penalty for late reporting. However, a hospital that fails to report can have its license withheld. There are no data on the timeliness of hospitals in filing this report, and there are no policies concerning modification of the reporting requirements.

Medi-Cal Cost Report

The Medi-Cal cost report uses the Health Care Financing Administration's HCFA 2552-96 form (the Medicare cost report) and supplemental schedules developed by the Department of Health Services. The latter consist of forms from the Audits and Investigations Division and the Rate Development Branch.

The Medi-Cal cost report and supplemental forms are due 150 days after the end of the hospital's fiscal year. The only extension allowed is for such catastrophes as earthquakes or fires. A hospital providing no services to Medi-Cal inpatients is exempt from filing the report. In addition, a hospital does not have to complete the report if it has no more than $50,000 annually in Medi-Cal inpatient charges and no more than 50 Medi-Cal patient days. However, if a hospital has a special program unit, such as a distinct-part skilled nursing, it must file the report. A hospital that provides only psychiatric services and does not have a cost settlement is not required to file the report.

If two or more hospitals have a consolidated license, then the number of Medi-Cal reports to be filed depends on their accounting practices. If there is only one general ledger for the facilities, then only one Medi-Cal cost report is required. If the facilities have multiple general ledgers, then multiple cost reports are required.

Use of a short or long fiscal period for the cost report may also be allowed. This is permitted when there is a change of ownership or other special circumstances. However, the minimum fiscal period is 1½ months, while the maximum is 13½ months.

The Medi-Cal supplemental cost report forms for the Rate Development Branch do not have to be completed by rural hospitals.

State Controller's Report

Healthcare districts (formerly known as hospital districts) must file a State Controller's Report that includes such information as financial statements, taxation and long-term debt. The Annual Report of Financial Transactions of Special Districts is due 120 days after the end of the June 30 fiscal year. There are no exceptions, exemptions or extensions. However, healthcare districts are allowed to use the OSHPD financial statements from their Annual Hospital Disclosure Report in lieu of completing the State Controller's forms.

ADDITIONAL DATA NEEDS

This section discusses additional data needs identified in the survey of data users. They do not necessarily reflect the views of the project team, which are set forth in another section.

The users' recommendations are arrayed by the specific reports. For a more detailed discussion of data user comments, see Part 5.

Disclosure Report

The data users made these suggestions for expanded data reporting:

- Counts of full-time and part-time staff according to occupational category and department. The intent here is to provide continuity of care proxies.
- Indication of the collective bargaining status of certain classes of employees. No publicly available database provides information on the number of employees covered by collective bargaining agreements in individual hospitals or groups of hospitals.
- Community benefits reported by not-for-profit hospitals to OSHPD as part of their responsibilities under SB 697 should be standardized and added to the Disclosure Report.
- A uniform definition of charity should be adopted. The reporting of charity is haphazard, varies widely between the Quarterly and Annual Disclosure Reports, and even varies widely *within* the Annual Disclosure Report as filings are amended. A uniform definition based on federal poverty standards would be a major improvement. It was also recommended that charity be identified by inpatient, outpatient and emergency services.
- Additional data on reproductive services.
- Additional data on SB 1255 and SB 855 revenues and transfer payments. Currently, on both the Disclosure Report and the Quarterly Report, total transfer-payment reporting is inconsistent, leading to grossly inflated net incomes for some public hospitals.
- Include data on individual Kaiser hospitals. One of the State's largest hospital systems is excluded from individual hospital reporting in the Annual Disclosure and Quarterly Report systems. This greatly compromises these systems.

- Distinguish zeroes from missing values.
- Develop uniform definitions of hospital systems instead of using open fields. Under the current process, identifying parent hospital systems is extremely time consuming due to minor word variations and spelling differences.
- To the extent feasible, eliminate open-ended fields with categories (*e.g*., occupations of board members, types of services provided by a management company).
- Add a "Home Office Report" for hospital systems, identifying their affiliated health-care businesses (*e.g.,* medical groups, HMOs, nursing homes, home-health agencies, surgery centers).
- Report deductions from revenue according to major payer and inpatient versus outpatient. (This would have to be accomplished in a manner that does not enable derivation of a hospital's confidential Medi-Cal per-diem rate.)

Additional recommendations regarding additional Disclosure data related to OSHPD adding data from other sources to its publications and data files, which would not affect hospital data-reporting responsibilities. This would involve: (1) adding a case-mix index derived from the discharge data; (2) adding area-wide demographic and health system data to the publications and OSHPD-generated summary reports.

Annual Utilization Report

The only recommendation for additional Annual Report data was to add patient demographic data for acute inpatients. Such data is currently reported for long-term care patients. (Such data is currently available in the Discharge database.)

Quarterly Report

While no specific additions were recommend for the Quarterly Report, it follows that some of the changes recommend for the Disclosure Report are also applicable. These include:

- A uniform charity definition
- Inclusion of Kaiser hospitals
- Complete data on SB 855 and SB 1255 revenues and transfer payments

ELIMINATION OF DATA

The evolution of our thinking regarding the elimination of data in the Annual Disclosure Report is set forth below according to major data category.

Hospital Descriptive Data – pages 1-3

The pages contain data describing the hospital in terms of service capability, ownership, medical staff composition, related organizations, governing board composition and management contracts. Initially, it was believed that much of this information could be eliminated. In particular, much of the information on page 1 (excluding the medical staff profile) appears in other parts of the Report; similarly with respect to the services inventory [pages 2(1) and 2(2)]; and all the information on pages 3.1-3.3, with the exception of financial arrangements with physicians, was viewed as expendable. Although we still believe that much of the descriptive data that are also included in other parts of the report can be dropped from this page, especially the services inventory [page 2(1)], the information called for on pages 3.1 and 3.2 (related organizations and board composition) should be retained. Several of the users interviewed have used these data and, given public-policy considerations related to community benefits and not-for-profit conversions, such data should be available.

Patient Utilization – pages 4.1(1)-4.2(4)

These pages provide information on inpatient and outpatient utilization according to service and major payer group, in addition to licensed, available and staffed beds by bed category. While these items should be retained, there is an opportunity to consolidate the Annual Utilization Report into these pages.

Financial Statements – pages 5(1)-9

These pages contain the balance sheet, long-term debt information, statement of changes in property, plant and equipment, statement of changes in equity, statement of income and statement of cash flow. Of all these statements, only the statement of changes in property, plant and equipment and the statement of cash flow appear to provide non-essential information.

Detailed Revenue Schedules – pages 12(1)-14

These pages provide gross revenue by cost center according to inpatient versus outpatient and according to major payer. While this level of departmental detail may not be frequently used, it provides some of the building blocks for cost allocation, and must be maintained.

Detailed Cost Schedules – pages 15-20

These pages provide the other building blocks for cost allocation, enabling calculation of full costs according to cost center. When matched with the revenue data from pages 12-14, costs can then be allocated between inpatient and outpatient, and to major payer. These pages are therefore essential.

Payroll and Staffing according to Cost Center – pages 21(1)-22.1

These pages provide data on staffing and wage and salary expenses by department according to broad occupational classification. They also identify costs and productive hours associated with registry personnel and other contracted services. This is highly useful information on hospital operations, especially in light of recently enacted legislation (AB 394) requiring the Department of Health Services to promulgate nurse-staffing standards.

Summary

Of the six major data categories discussed above, data elimination appears feasible in three: (1) hospital descriptive (eliminate information that is generally available in the patient utilization sections); (2) patient utilization (consolidate the Annual Utilization Report into this section); and (3) financial statements (eliminate the cash flow and changes in property, plant and equipment statements).

CONSOLIDATION OF REPORTS

Background

As prescribed by SB 1973, a major focus of this project is to "identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical." This section of the report discusses three existing hospital data reporting mechanisms, their overlapping or redundant requirements and identifies potential opportunities for reporting consolidation.

The three major hospital data reporting mechanisms reviewed are the Medi-Cal Cost Report, OSHPD Annual Utilization Report and the State Controllers Report. Each is addressed in papers that discuss why the issue raises concerns. These issue papers then offer a thorough discussion of subordinate issues within each topic area.

The issue papers presented in this section were used extensively by the project team to solicit input and responses from various state agencies, hospitals and data users. The findings from these interviews appear in a separate section of the report. However, the following section provides a detailed analysis for each specific issue.

Medi-Cal Cost Report

ISSUE:

Are there opportunities for consolidating the Medi-Cal cost report and the OSHPD annual utilization report?

WHY THIS IS AN ISSUE:

Both the Medi-Cal cost report and its related supplemental schedules, and the OSHPD disclosure report, require extensive financial and utilization data collection and reporting by hospitals. The information is then collected, processed, and edited by two separate state agencies. This may result in redundancies, inefficiencies and excess costs. If these two reports were to be combined, could the objectives of both OSHPD and the Medi-Cal program still be accomplished?

POINTS TO ADDRESS:

Are public disclosure and reimbursement needs mutually exclusive?

The answer depends on the type of reimbursement system in place, and the reporting mechanisms used to determine the appropriate levels of reimbursement. Under Medi-Cal, acute care hospitals are reimbursed for inpatient services by one of two methods—an independent contract rate, or reasonable costs as determined through the cost report. The reasonable cost process may or may not be subject to a further reimbursement limitation that utilizes data obtained from the cost report and Medi-Cal supplemental reports.

For outpatient services, Medi-Cal reimburses hospitals based upon a fee schedule that does not use the cost report. The Medi-Cal cost report data is also used to establish prospective payment rates for distinct part skilled nursing services provided to Medi-Cal beneficiaries.

All hospitals providing inpatient Medi-Cal services must file a Medi-Cal cost report with the Department of Health Services (DHS) within five months of the close of their fiscal year. This is a requirement whether the hospital is or is not reimbursed through the cost report. Slightly less than half the hospitals are reimbursed for inpatient services through the cost report, accounting for less than 10 percent of the Medi-Cal inpatient dollars. The Medi-Cal cost report filings include HCFA Form 2552-96, two Medi-Cal supplemental forms and one County Medical Services Program (CMSP) supplemental form, where applicable.

Information is submitted to DHS for reimbursement of Medi-Cal inpatient services, while data submitted to OSHPD are intended for public disclosure. The former focuses on “reasonable and allowable costs” and the latter on “actual costs.”

The question that must be addressed is whether these two reporting mechanisms can be modified to achieve the necessary efficiencies without jeopardizing

the two differing objectives. Issues to consider include the number of hospitals actually being reimbursed through the cost report, as well as the type of services that are being reimbursed. In addition, are the current desk and field audit functions duplicative, is most of the collected data duplicative, and can modifications be made to each report to achieve the efficiencies of consolidation without interfering with the objectives of reimbursement and public disclosure?

Are California's hospital accounting and reporting requirements consistent with Medi-Cal reimbursement principles?

In general, the answer to this question is yes. California hospitals are required to keep a chart of accounts consistent with the functional accounting system prescribed by the OSHPD. Therefore, almost all California hospitals have the same accounting system already in place, and use it to make the necessary reclassifications or adjustments to complete their Medi-Cal cost report and supplemental worksheets. The differences lie in the reporting mechanisms, not the accounting systems.

An additional issue that should also be considered is that the Medi-Cal cost reporting forms are obtained from the Health Care Financing Administration (HCFA), and are little more than the Medicare cost reporting forms with some added, specific Medi-Cal payment information. As Medicare moves away from cost reimbursement and develops reimbursement methodologies specific to its needs, the HCFA 2552 cost reporting forms may contain items completely irrelevant to the Medi-Cal program.

We are already beginning to see some of these changes. California's Medi-Cal program has no control over these changes and will have to find alternative ways to collect information. A recent example is reimbursement for hospital-based physician costs; Medicare deleted a cost report schedule still being used by Medi-Cal. It may be that OSHPD's accounting and reporting requirements will more closely resemble those of Medi-Cal rather than Medicare.

How extensive would reporting modifications be if these reports were to be combined?

This discussion compares the Medi-Cal cost report HCFA Form 2552-96 with that of the OSHPD annual disclosure report; these are the most significant reporting requirements of each organization, as well as the most related. However, the Medi-Cal supplemental forms (including Rate Development Branch worksheets) could also be included in a consolidation, because all information required by these worksheets comes from the OSHPD disclosure report, the Medi-Cal cost report, or other data already available within DHS.

This comparison focuses on the most significant and basic components of the Medi-Cal cost report and the OSHPD annual disclosure report. It identifies the major differences and explains whether the objectives of reimbursement or public disclosure would be affected if either report were changed to achieve a consolidation.

DEMOGRAPHIC DATA: Both reports collect almost identical demographic information. Either report can be modified without impacting their objectives.

FINANCIAL STATEMENTS: Both reports require hospitals to submit basic financial statements (e.g. balance sheet, income statement) on prescribed worksheets, as opposed to only including the year-end audited financial statements. Modifications to either report should not impact their objectives.

DETAILED REVENUE INFORMATION: The OSHPD report requires inpatient and outpatient revenues by department for a variety of payers, and recently has been modified to distinguish between fee-for-service revenues and managed care revenues. The Medi-Cal cost report requires total revenues, by inpatient and outpatient, by department. It also requires inpatient Medi-Cal fee-for-service revenue by department to be reported.

Revenues for the OSHPD report are usually provided by information from the hospital's revenue distribution and general ledger. The Medi-Cal cost report is usually completed from the same information source, except for Medi-Cal revenues, which are based upon covered charges usually derived from the hospital's reimbursement logs or the Medi-Cal paid claims summary. Modifications can be made to account for these differences where reimbursement is a factor.

DETAILED EXPENSE INFORMATION: The OSHPD report requires total expenses by department by various natural classifications. These include salaries, benefits, professional fees, supplies, purchased services, depreciation, rents and leases, and other expenses. The Medi-Cal cost report also requires the reporting of expenses by department, but limits the natural classifications to salaries and other. Other differences include the establishment of non-reimbursable cost centers and the inclusion of vacation, holiday and sick leave as salary expense within the Medi-Cal cost report. Modifications can be made to account for these differences where reimbursement is a factor.

RECLASSIFICATIONS AND DISALLOWANCES: The Medi-Cal cost report requires certain expenses to be reclassified to follow specific reimbursement principles. In addition, certain expense departments are either increased or decreased to account for revenues from non-Medi-Cal sources, or to account for certain costs not reimbursable by Medi-Cal. These reclassifications or disallowances are specific to Medi-Cal reimbursement policies and distort the true costs incurred by hospitals. A consolidated report would have to preserve both reimbursement principles as well as the OSHPD public disclosure objectives.

PAYROLL INFORMATION: The OSHPD disclosure report requires payroll information by department. It discloses productive hours and hourly rates by employee classification (*e.g.* management, technicians, nursing staff, clerical staff), and non-productive and total paid hours by department. The Medi-Cal cost report only provides for total FTEs, and FTEs by department as an allocation statistic. The Medi-Cal supplemental schedules also collect the identical payroll information as found on the OSHPD disclosure report to calculate one of the

payment limitations. Incorporating this information into a consolidated report should not impact either department's objectives.

ALLOCATION STATISTICS: Both reports require overhead costs to be allocated to the patient care departments based upon prescribed allocation statistics. The differences include some of the prescribed allocations statistics, although not very many, and the departmental order of the cost-finding process. A thorough examination of objectives would have to be made to determine how the step-down process could be modified and the financial impacts analyzed. It is possible to provide for multiple allocation methodologies with the same statistics and departments. This could be accomplished with little resources or effort.

UTILIZATION STATISTICS: The OSHPD requires the detailed reporting of utilization statistics by cost center that relate to census information, ancillary and ambulatory departments, and support services. Daily hospital services and ambulatory services data are also reported by payer category. The Medi-Cal cost report requires utilization statistics that only relate to census information. An appropriate consolidation of reporting can be made without disrupting the objectives of the reports.

EXEMPTION/EXCEPTION ISSUES: OSHPD allows various exceptions and exemptions to reporting requirements. These include accounting system modifications, reporting periods that may differ from the normal 12-month periods, and exemptions for specific types of hospitals. Medi-Cal also has various exceptions and exemptions, including allowing reporting periods that may differ from the hospital's fiscal year-end, and modifications in use of specific allocation statistics. There may also be a question of whether a hospital provides any Medi-Cal acute care services. These critical issues will need to be clearly identified and resolved before any consolidation could occur.

Are there timeliness issues associated with a consolidated report?

The OSHPD annual disclosure report is due four months after the hospital's fiscal year end, with allowances for extensions up to 90 days. The Medi-Cal cost report is due five months after the hospital's fiscal year end with no allowances for routine extensions. Because the Medi-Cal cost report is used to settle under and over-payments, as well as to set prospective payment rates for skilled nursing patients, it appears that the time frames for submitting data may not be compatible. The question is whether the OSHPD disclosure report can be completed and submitted within Medi-Cal's prescribed time limits.

Would consolidation result in the same report submitted to two separate state agencies, or could there be more efficient collecting, processing, editing, auditing and disseminating of data in these two reports?

If consolidation is a viable option, then efficiencies could best be achieved if hospitals submitted one report to one state agency. The state agency receiving the information could then process and distribute it. Whichever organization collects the data could then process it in the formats necessary to accomplish the objectives of the other organization. The funding levels currently available to

each agency for the administrative functions related to collecting, processing, auditing and disseminating the data in the two reports could be consolidated and re-distributed based upon combined functions. It is likely that the combined functions would result in significant cost savings. A complete evaluation of data elements necessary for this consolidated report, as well as an examination of each organization's current responsibilities will help determine how these administrative functions should be combined.

It should be noted that Section 128730 of the Health and Safety Code requires the consolidation of these reports to the extent feasible to minimize the reporting burden on hospitals. This law became effective on January 1, 1986, and has yet to be implemented for these two reports.

Annual Utilization Report

ISSUE:

Should the Office's "Annual Utilization Report of Hospitals" be merged with the "Annual Hospital Financial Disclosure Report" or the "Hospital Quarterly Financial and Utilization Report"?

WHY THIS IS AN ISSUE:

The Annual Utilization Report contains detailed patient utilization data by licensed bed categories as well as additional volume data—such as births, cardiovascular surgery and emergency visits—on a calendar-year basis. The Annual Disclosure Report contains some of the same detailed inpatient volume data on a hospital-specific, fiscal-year basis. The Quarterly Report contains some aggregate volume data. Thus, there appears to be some overlap between the three reports. It may be more efficient to combine the Annual Utilization Report with one of the others to lessen the burden for those reporting as well as those processing the information.

POINTS TO ADDRESS:

Are there enough similarities between the Annual Utilization Report and the other two reports to make it possible to combine them?

Because the Annual Disclosure Report and the Quarterly Report contain significant amounts of financial data while the Annual Utilization Report does not, it does not appear feasible to merge either of the former two reports into the latter. It does, however, appear possible to merge the Annual Utilization Report into either of the other two reports, and thus reduce reporting burdens on hospitals.

Merging the Annual Utilization Report into the Quarterly Report, although feasible, would accomplish little or nothing. The Quarterly Report contains only highly aggregated inpatient volume and capacity data (*i.e.*, total beds and total and long-term patient days and discharges). On the other hand, the Annual Disclosure Report includes many of the same data items as the Annual Utilization Report, and a slight expansion and modification of the Annual Disclosure Report could eliminate the Annual Utilization Report altogether.

Are there any other similar reports with which the Annual Utilization Report could be merged?

Medical records staff in the hospital generally complete the Annual Utilization Report, because they are the source for most of the required information. Medical records staff also collect the required data and prepare the Discharge Data Report submitted by hospitals every six months. Thus, there appears to be a potential for consolidating these two reports.

Some Annual Utilization Report data are already available through the Office's discharge data system. For long-term-care patients, the Annual Utilization

Report collects age, sex and ethnicity information. For subacute care, the Annual Utilization Report collects data on broad age groups, admission source and discharge status and specific procedures. All this information could be generated from the discharge data reports if they were modified to identify subacute patients. It should be noted that evaluating current discharge data reporting requirements is outside the scope of this review.

The differing time periods of reports could affect any consolidation.

Except for hospitals whose fiscal year is a calendar year, the current reporting periods differ for the Annual Utilization Report (calendar year) and the Annual Disclosure report (hospital fiscal year). The Discharge Data Report is prepared on a six month, calendar-year basis.

The Annual Utilization Report was developed in the 1970's to support the health planning and Certificate of Need programs. It was administered by the now-defunct California Health Facilities Commission, while the Annual Disclosure Report was administered by the Department of Health. For Certificate of Need proceedings, it may have been perceived that a consistent point-in-time bed inventory and utilization rate was necessary, given the quasi-judicial nature of the program. Moreover, there was a less than ideal working relationship between the two competing agencies. At this time, a uniform point-in-time snapshot appears no longer necessary.

If the Annual Utilization Report were combined with the Annual Disclosure Report, the Office could prepare data files and reports for the public by several reporting cycles (*e.g.*, fiscal years from June 30 to June 29, and from December 31 to December 30). It is likely the loss in precision would be negligible.

The Office could easily test this assumption prior to deciding on such a consolidation. If the Annual Utilization Report were combined with the Discharge Data Report, there is no reason why the data collected on the Annual Utilization Report couldn't be collected in six-month increments, using the discharge data reporting cycle.

Is it necessary to collect all the data required in the Annual Utilization Report?

Some data collected on the Annual Utilization Report may no longer be useful, and its elimination would make it easier to consolidate reports. For example, the Annual Utilization Report collects detailed information on megavoltage machines (*i.e.*, the age of each machine, days in operation, treatment visits and photon or electron mode). In addition, the Annual Utilization Report collects highly detailed data on subacute patients, including procedures. The Annual Utilization Report also collects December 31st census data. If still necessary, these data items could be added to the Annual Disclosure Report or the Discharge Data Report. Otherwise, the data could be eliminated from the consolidated report.

If consolidation occurs, how could the transition be eased for data users?

If the Annual Utilization Report is consolidated with either the Annual Disclosure Report or the Discharge Data Report, the Office should continue preparing Annual Utilization Report data files and publications (drawn from a subset of the expanded ongoing report) on a timely basis, including necessary discharge report summary data, so that the Annual Utilization Report user will not experience a disruption or worsening in data access.

State Controller's Report

ISSUES:

Are there opportunities for consolidation of the Annual Report of Financial Transactions of Special Districts (State Controller's Report) and the annual OSHPD disclosure report?

WHY THIS IS AN ISSUE:

The State Controller's Report requires Healthcare District hospitals to file information already filed with the Office of Statewide Health Planning and Development (OSHPD), and supplemented with some related, detailed balance sheet data. The data are collected, processed and edited by two separate state agencies. Combining these administrative functions should be more efficient.

POINTS TO ADDRESS:

Why is this information collected by the State Controller's Office?

Government Code Section 53891 requires the completion of this report for all California "local agencies." That includes any city, county, any district, and any community redevelopment agency required to furnish financial reports pursuant to Section 12463.1 or 12463.3 of the Government Code.

The report has been designed for all "local agencies," not specifically hospital districts. There are approximately 4,800 "local agencies," only 78 of which are healthcare districts. Section 53891.1, however, modifies the reporting for healthcare districts by allowing them to replace the report of all financial transactions with specific report pages from the OSHPD annual disclosure report. These are then supplemented with detailed balance sheet-related information specified in Sections 53892 and 53892.2 of the Government Code, and year-end audited financial statements.

The Government Code does not explain why the data are collected, who uses the information and for what purpose, and whether it is still necessary to collect the data elements. According to staff at the Controller's office, the information is used in an annual publication of data from all special districts. The data is made available to the Legislature through this publication. In addition, the Controller's office at times provides copies of the actual reports and prepares special requests with the collected data. These special requests usually do not involve the hospital reports.

Other than copies of the OSHPD disclosure report pages, what other data appear on the Special Districts' Annual Report?

The following type of information is collected in detail on the Special Districts' Annual Report:

- Statistical information related to tax assessments, revenues and taxation that may be needed by any Senate or Assembly committee on revenue and taxation.
- Specific information related to any applicable general obligation bonds, revenue bonds, improvement district bonds, limited obligation bonds and special assessment bonds.
- Specific information related to all lease-obligations.
- Detailed information related to any construction that is financed through an arrangement with the state or federal government.

Is the information contained in the Special Districts' Annual Report reviewed or edited?

The information is transmitted in hard copy and reviewed by a desk audit. There are currently two staff assigned to hospital district reports, although they are also responsible for the reviewing reports from other types of special districts. The data are reviewed for reasonableness, completeness and consistency between years. The information is then entered into a database for further internal edits. The Controller's office is seeking a contractor to develop a system for the electronic submission and editing of this report.

Is the information required by the Special District's Annual Report ever analyzed to determine if updating is warranted?

It appears the information collected is strictly based upon the requirements of specified government code sections, and is not analyzed or modified on a regular basis, if at all. There does not seem to be a forum for those who use the data to provide input on changes that might need to be made.

Are there any advantages in combining the OSHPD Annual Disclosure Report and the State Controller's Report? If so, how would a consolidation be approached?

It should first be noted that any consolidation of the State Controller's report and the OSHPD annual disclosure report would involve only the 78 hospital districts. The remaining 4,700-plus special district reports do not relate to hospital activity and would be excluded from this process.

Any consolidation would likely require district hospitals to report directly to OSHPD, which would then provide the State Controller's Office with their required information. This approach makes the most sense, because the district hospitals already include copies of the OSHPD annual disclosure report financial statements and revenue reports to the State Controller's Office. In addition, OSHPD requires more detailed information from all hospitals, including the district hospitals, and could, therefore, spin off a portion of the data to the State Controller's Office. Also, OSHPD currently collects the data electronically and performs detailed edits, as well as a random field audits.

To reverse the process would require the State Controller's Office to expand both its data collection and editing processes, but would not reduce any activities currently performed by OSHPD for other hospitals. If the State Controller's Office were to receive an edited, electronic file of 78 hospital reports, it eliminates its time and costs associated with collection and processing of this information. In addition, the editing process would be uniform if performed by one agency. Even more significant efficiencies would be gained by the hospitals filing the reports. They would have one due date, one edit process and one set of reports to file. Finally, data users could access the information from one agency.

How extensive would be the reporting modifications if these reports were to be combined?

The information in the State Controller's report on taxation, bonds, lease obligations and construction financing is not collected on the annual OSHPD disclosure report in the same detail. However, this can be addressed in a variety of ways. First, determine how the specific information is being used, and what is important and unimportant. Eliminate any unused information from the requirements of the Government Code. The remaining data requirements can then either be added to the OSHPD disclosure report, through a modification to the balance sheet, or through supplemental balance sheet pages similar to the fixed asset and long-term debt schedules. The supplemental page would only be required for district hospitals.

Are there timeliness issues associated with a consolidated report?

The OSHPD annual disclosure report is due four months after the hospital's fiscal year end, with allowances for extensions up to 90 days. The State Controller's report is due four months after the hospital's fiscal year with no allowances for extensions. If a State Controller's report is not filed within 20 days of written receipt of a notice of failure to file, a fine may be assessed. Because most hospitals request and receive extensions from OSHPD, the State Controller's Office currently does not enforce fines for late filing within the prescribed time deadlines set by OSHPD. Therefore, it does not appear that there would be any timeliness issues with respect to filing deadlines.

One issue of timing would have to be addressed: OSHPD's ability to edit, process and transmit data to the State Controller's Office in time to meet their annual publication deadlines.

HOSPITAL ACCOUNTING AND REPORTING PRACTICES

Background

The issue papers in this section provide a detailed discussion of relevant hospital accounting and reporting practices. These practices may have a material bearing on the accuracy, timeliness and usefulness of data collected, analyzed and reported in the OSHPD financial and utilization data system.

The issue papers are highly specific and raise numerous questions about individual topics. However, there are several fundamental, and recurrent, accounting issues. These basic accounting issues include:

- Accuracy in data collection;
- Inconsistency in data reporting standards;
- Inconsistency in interpretation of data reporting standards;
- Data deemed unnecessary and therefore inaccurately collected;
- Data collection requiring complex processes, leading to inconsistency or inaccuracy;
- Results reported in a manner which leads to misinterpretation; and
- Results presented in a manner inappropriate to the data source, collection method or statistical validity.

The basic accounting issues are not specifically addressed by the following issue papers, but should be kept in mind nonetheless. The papers highlight how the basic accounting problems become compounded into substantial hospital financial and utilization data reporting concerns. The issue papers also illustrate major concerns faced by the various entities that report, collect, analyze or otherwise use of the end products of the financial and utilization reporting system.

Capitation

ISSUE:

Are expenses from outside capitated services properly accounted for in the OSHPD manual and consistently reported by hospitals? Should expenses for patients receiving services from another provider under a capitation agreement be recorded as operating expenses of the hospital not providing the service, but whose capitated contract requiring it to pay for the services?

WHY THIS IS AN ISSUE:

Operating expenses may be recorded in two hospitals for the same services, as capitation contracts become more commonplace. Under these arrangements a hospital generally liable for a patient's medical care whether the service is rendered there or at another facility. In essence, the hospital for a fixed fee, normally per-member-per-month, accepts responsibility for the member's health care.

There is no issue when the hospital provides services to a member under its own capitated arrangement. The hospital records its normal revenues and incurs expenses for caring for the patient. The hospital then recognizes the appropriate amount of capitation fees (deferred revenue) as payment for the charged revenue. The issue arises from services provided to members at facilities other than at the hospital with the capitation arrangement.

The following scenarios appear in section 1221 of the OSHPD's *Accounting and Reporting Manual for California Hospitals* regarding this issue:

> *"1. A member is admitted to the contracting hospital and all daily and ancillary services are directly provided by that hospital. The gross revenue, expenses, and units of service are recorded in the functional centers related to the services provided.*
>
> *"2. A member is admitted to the contracting hospital and most, but not all, ancillary services are directly provided by that hospital. For example, although the patient remains as inpatient of the contracting hospital, the contracting hospital must purchase computed tomographic scanner services from another hospital or organization. In this case, the gross revenue, expenses, and units of service related to all purchased ancillary services must be recorded by the contracting hospital in the functional centers related to the services provided even though purchased from another hospital.*

"3. A member is not admitted to the contracting hospital but is admitted to another hospital (or to a skilled nursing or intermediate care facility which is not operating under the license of the contracting hospital) with the approval of the contracting hospital. Since the contracting hospital is responsible for all of the cost of the services provided by the admitting hospital, the admitting hospital will bill the contracting hospital for the care provided. Because the member was not admitted to the contracting hospital, it is inappropriate to record the expenses and related units of service [patient (census) days, surgery minutes, etc.] in the functional cost centers of the contracting hospital. It is also inappropriate to gross up the revenue of the contracting hospital related to the services provided by the admitting hospital. However, since the contracting hospital is responsible for the cost of the services provided and has received capitation fees to provide all inpatient services, such cost must be recorded as patient service expense.

"4. A member is first admitted to the contracting hospital but during the same episode of care is transferred and admitted to another hospital, or vice versa. In this case, the services provided by the contracting hospital would be accounted as described in 1 or 2 above and the inpatient services provided by the other hospital would be accounted as described in 3 above…."

The same section goes on to indicate:

"…The expenses related to purchased inpatient services must be recorded in Account 7900, Purchased Inpatient Services."

Some hospitals are concerned over recording purchased inpatient services as an operating expense, and have been reporting purchased inpatient service expenses as a reduction of capitation premium revenue—contrary to the OSHPD Manual instructions. These hospitals believe that the services provided at other facilities are not patient-related, but rather an insurance function or arrangement.

Other hospitals believe that the recording of purchased inpatient services as expenses significantly overstates their patient activity, but continue to comply with the OSHPD Manual requirements.

POINTS TO ADDRESS:

Is the outside payment under a capitation plans patient care related?

The issue centers on the Manual determination that "since the contracting hospital is responsible for the cost of the services provided and has received capitation fees to provide all inpatient services, such costs must be recorded as patient service expenses." The issue is not whether expenses need be recorded

for patient services rendered at other than the contracting hospital, but whether the expenses should be considered by the contracting hospital as patient care operations.

In reviewing how the capitation revenues should be recorded, the American Institute of Certified Public Accountants Audit and Accounting Guide entitled *Health Care Organizations* was consulted. Paragraph 10.04 characterizes the "premium revenues" as operating revenues but separate from Patient Service Revenue. This paragraph states:

> *"10.04 Revenue usually is recorded when coverage is provided to an enrollee or the service is provided to a patient or resident. Revenue is classified based on the type of service rendered or contracted to be rendered. Examples of revenue include—*
>
> *Patient service revenue, which is derived from fees charged for patient care. This may be based on diagnosis related group (DRG) payments, resource-based relative value scales (RBRVS) payments, per diems, discounts, or other fee-for-service arrangements.*
>
> *Premium revenue, which is derived from capitation arrangements.*
>
> *Resident service revenue, which may be related to maintenance fees, rental fees, or amortization of advance fees."*

This section of the Audit Guide does not indicate whether premium revenue is net of payments to other hospitals for capitated member services or whether these purchased inpatient services are recorded as operating expenses. The Audit Guide goes on to say in paragraph 10.19 that, "significant revenue earned under capitation arrangements is reported separately." Furthermore, the Guide shows the revenue from premiums separate from patient service revenue on the sample financial statements.

When hospitals accept capitation payments for services at their facility, they also accept payment responsibility for services not rendered there. Generally Accepted Accounting Principles define an expense as outflows of assets or incurrence of liabilities from carrying out activities that constitute the entity's ongoing major operations. Items that should be considered to determine if the non-hospital services should be included as patient and operations-related are:

1. Is the payment to other hospitals under a capitation agreement related to the operations of the hospital?
2. Is the fact that payments are made to other hospitals for patients who are not registered or admitted patients to the hospital making the payments an indication that the expense is not patient-related?

3. Is the fact that revenue in scenario 3 above is not adjusted to the hospital's rates an indication that the expense is not patient-related?

4. Should there be a difference in accounting and reporting procedures for capitated patients vs. non-capitated patients, such as Medi-Cal contract patients who receive care at a non-contracting hospital?

Does the current method of reporting expenses overstate the state's overall hospital costs?

Reporting capitation payments to other hospitals as patient revenue and operating expenses may overstate revenue and expenses of hospitals on a statewide basis. When a patient is treated at a hospital without a capitation arrangement, the treating hospital records expenses as with any other patient. It then bills the hospital that does have the capitation agreement. The hospital that receives the bill from the treating hospital then records expenses related to the same patient. (See scenario 3 above.) Both hospitals record operating expenses, even though only one hospital provided service, so there is a duplication of reported expenses.

Charity and Bad Debt

ISSUE:

Can steps be taken to more consistently and accurately identify and report charity care and bad debt?[1]

WHY IS THIS AN ISSUE:

Charity and bad debt information is frequently used in public policy debates on the appropriate role of hospitals, particularly non-profit hospitals. In addition, Tobacco Tax funds are allocated to counties and hospitals primarily based upon charity care rendered by hospitals. Currently, the Office provides general criteria concerning charity and suggested factors to consider within Section 1400 of the *Accounting and Reporting Manual*. Specifically, the manual references the Healthcare Financial Management Association Principles and Practice Board, Statement #2. However, there are no precise criteria for hospitals to follow in identifying charity care. Accordingly, each hospital makes its own decision about charity and bad debts. Anecdotally, a number of patients without the ability to pay are identified as bad debt rather than charity. Any comparison of hospitals by the amount of charity care provided is suspect because of these inconsistencies.

POINTS TO ADDRESS:

Is there a need to assure that hospitals accurately report charity and bad debt?

The importance of accurately reporting data on hospital charity care is difficult to determine. Tobacco Tax funds are distributed to hospitals based on formulas that take into account charity care, which supports the need to accurately report the information. There have been a number of public policy discussions on the roles of non-profit hospitals and those hospitals that convert from non-profit to investor-owned status. County hospitals and other facilities have been compared by the value of not only charity care but also other indigent care they provide. In some instances, the discussion of charity care appears to be motivated by other factors rather than charity care issues alone.

Nevertheless, there appears to be strong sentiment among several groups that charity is an important data element that should be reported correctly. In addition, the hospital community itself has also been vocal in expressing a desire that its constituents properly report what benefits they provide, including charity care.

What are the impediments to more accurately reporting charity care data?

[1] In this discussion, charity care is limited to reductions in charges for services and does not include other forms of community benefits.

Many factors affect the reporting of charity. One is that there is little incentive to classify a patient as a charity care case rather than as a bad debt. In either case, the hospital receives no payment. Some hospitals have developed lengthy forms and processes for determining eligibility for charity. Because of the paperwork involved and the need to obtain detailed information on the patient's financial condition, there is a disincentive for staff to classify a patient as a charity patient.

Another possible impediment may be a hospital's reluctance to report significant amounts of charity. Hospital managers often hope to eventually be reimbursed for unpaid services. This tendency to try to collect payment from the patients is particularly seen in many smaller hospitals that have patients on payment plans that would require several years to pay off the bill. For example, there are payment plans of less than $50 a month for a bill that is $2,000 or more. Even if no interest is assessed, payments of this size would last more than three years. Hospital management sometimes express the concern that writing off accounts as charity care would invite additional patients to not reimburse the hospital for care—even it they had the means to do so.

Does the importance of accurate data outweigh the cost to the hospitals to produce the data?

Hospitals currently establish their own charity policies and procedures, and consequently have a great deal of control over the difficulty and cost of the process. However, even a relatively streamlined charity determination process would have an added cost compared to writing off such care as a bad debt. The billing and collection process for hospitals is already extraordinarily complex and mistakes are dangerous because of federal and state fraud initiatives. Many hospital billing activities involve high volumes of information and human intervention has been minimized for the sake of efficiency. Thus, the extra work to classify charity patients may be difficult for hospitals to deal with. And of course, any new procedures and policies must overcome the natural inertia and resistance to change.

Are there important differences for the patient in the way charity and bad debt patients are treated?

Ideally, the patient who is unable to pay should be identified at the onset of service and the necessary steps taken to classify the service as charity so that no attempt at collection is made. However, this ideal situation cannot always occur. Often the identification of a patient without financial resources occurs only after the services have been provided and collection activity has begun. Even though the existence of charity care programs at hospitals must be posted, patients are not always aware of them. In some instances, patients will indicate they have third party coverage when they do not, or there is no coverage for the particular medical situation. Only after attempting to verify coverage and/or collect from the third party will the hospital attempt collection from the patient. In this situation, the financial documentation will not have been obtained from the patient at the initial registration. Once the efforts to collect from the patient have begun, the lack of financial resources may become known.

Once eligibility for charity care has been established, collection efforts cease and the patient is treated differently. Thus, the distinction is important to the patient. This emphasizes not only the need to identify charity care patients, but to do so as soon as possible. However, as a practical matter, it will never be possible to identify all charity care cases when they first appear. As noted above, patients are often unclear about their medical coverage in some cases the patients are physically or mentally unable to provide the information needed to make a charity care determination.

Should there be a standard definition of charity to which all hospitals must adhere? Should there be a standard process for identifying charity care?

As noted previously, while the Office suggests charity care criteria, it does not mandate the criteria or the process hospitals use to identify charity care. OSHPD does require written, established guidelines for determining charity care eligibility, as well as documentation for patients. This must be followed consistently for all patients.

In some other states there are specific standards for what constitutes charity care. These standards sometimes involve the forms and process used for eligibility determination. In Massachusetts, charity care information is used to distribute significant uncompensated care pool funds, making the consistent identification of charity more important. Similarly, in California, the allocation of Tobacco Tax funds is made, in part, on the basis of the cost of charity care at specific hospitals. Medi-Cal disproportionate share allocations are also based upon the reporting of charity care. Therefore, a standard definition could make the allocation more equitable.

On the other hand, a number of factors in California suggest it would be inappropriate to mandate uniform charity care standards. California is a very large state with great diversity in its geography and population. The standards for charity applicable to San Francisco residents should probably be different than those in a small, isolated rural community. Cultural differences also affect the ability of Californians to access health care and could be a consideration in any mandated charity guidelines. The effort to develop, implement and maintain equitable charity care standards throughout the state would be tremendously burdensome to any state agency. An alternative to statewide standards that would maintain some flexibility is to enhance accountability at a local level. The exact mechanism for doing so would have to be developed.

Additionally, organizations representing hospitals contend the definition and determination of charity care must be left to the hospitals' individual discretion. Their position is that the hospital is in the best position to understand the needs of its own community, including the need for charity care services. Furthermore, the individual hospital must make a judgment as to what it is financially able to do to meet those needs.

There is also the question of the proper role of government in mandating standards that would require private entities (including investor-owned and non-profit hospitals) to provide a service for which they will not be reimbursed. Some groups believe this is an appropriate requirement for all hospitals; others do not. If there were funds available to reimburse a major portion of the charity cost, a more persuasive argument could be made that the government should impose consistent requirements for identification and reporting.

Uniform Accounting (Responsibility or Functional Accounting)

ISSUE:

The OSHPD uniform accounting and reporting system was set up on a functional accounting basis. Many providers have a different internal need for either responsibility accounting or product line accounting. Should these providers have to keep two sets of accounting records to fulfill the OSHPD reporting requirements?

WHY IS THIS AN ISSUE:

OSHPD chose the functional accounting basis intentionally. Paragraph 2010 of the OSHPD's *Accounting and Reporting Manual for California Hospitals* explains why:

> *"Functional Accounting may be defined as the accounting of costs according to type of activity.*
>
> *"Responsibility Accounting may be defined as the accounting of costs according to organizational units, such as departments.*
>
> *"Total costs are the same with either functional or responsibility accounting. Each accounting system serves different purposes. Responsibility accounting is necessary for evaluations made of and by management. However, because organization structures vary among hospitals, responsibility accounting does not allow the comparability necessary for reporting to the Office. Therefore, an accounting and reporting system had to be developed which allowed comparable reporting of hospital activity among hospitals, while not significantly disturbing a system of responsibility accounting and reporting.*
>
> *"Although the accounting and reporting concepts and principles incorporated into this Manual are set down along functional lines, they should not, in the majority of cases, alter the individual hospital's responsibility accounting and reporting. Where differences occur (and this will vary with individual hospitals) reclassifications are necessary in order to conform the hospital's books to the OSHPD accounting requirements. However, in order to minimize the number of reclassifications, the hospitals must align their responsibility centers as close as possible to the functional centers as described in this Manual. Factors influencing this alignment might be (1) type of services and (2) size of the hospital."*

In theory there is no conflict between the responsibility accounting systems that hospitals use and the OSHPD functional accounting system. The reality is that there are significant conflicts. An example below describes such conflicts between responsibility and functional accounting. The issue in this example is representative of the broader issue of responsibility versus functional accounting.

Example: Chargeable Supplies and Pharmaceuticals. Hospitals are having difficulty complying with the OSHPD manual regarding the accounting for all charges related to Medical Supplies and Pharmaceuticals in the Medical Supplies Charged to Patients and Drugs Sold to Patients departments.

Comparable OSHPD revenue data may not exist for Medical Supplies Charged to Patients, Drugs Sold to Patients, and any department that accumulates charges for supplies and pharmaceuticals sold to patients. Hospitals often charge for supplies and pharmaceuticals out of multiple departments. These departments may include Emergency Services, Operating Room, Oncology and certain Radiology departments along with the Central Supply and Pharmacy departments. The charges and costs of supplies and pharmaceuticals sometimes remain in the department generating the charge versus being transferred to Medical Supplies Charged to Patients and Drugs Sold to Patients departments as outlined in the OSHPD manual. This is because hospitals account for chargeable supplies and pharmaceuticals under a responsibility accounting method rather than a functional accounting method. Reclassifications of these charges are not made because of the difficulty involved. Typically the revenue and expense of these items remain in the using department; thus, there is no mismatch of revenue and expense. If a reclassification of only expense or revenue is made, then revenue and expense will no longer match. It has not been determined whether analysis of the revenue by department by users is materially affected by this difference in accounting and reporting.

Are the current OSHPD reporting requirements clear?

Per the *Accounting and Reporting Manual For California Hospitals* (Manual) paragraphs 1103.1 and 1103.02, revenue and expenses for chargeable supplies and pharmaceuticals are required to be reported in the Medical Supplies Charged to Patients (Department 4470) and Drugs Sold to Patients (Department 4710) regardless of where the item was used. The manual states in 1103.1:

"Central Services and Supplies

"Central Services and Supplies (Account 8380) is the overhead cost center where the cost of all supplies purchased is recorded. The direct cost of medical and surgical supplies issued by this cost center, for which a separate charge is made to patients, must be transferred from this cost center to the Medical Supplies Sold to Patients cost center (Account 7470). The related revenue must be reported in the Medical Supplies Sold to Patients revenue center (Account 4470). This requirement applies regardless of which cost center the item is used in. For example, the cost and revenue related to surgical supplies for which the patient is charged must not be recorded in the Surgery and Recovery Services cost/revenue center, but in the Medical Supplies Sold to Patients revenue/cost center..."

Similarly, in section 1103.2, the manual states:

"Pharmacy

"Pharmaceutical supplies and materials issued by the Pharmacy for which a separate Pharmacy charge is made to a patient must be accounted for as a cost of supplies and materials to the Drugs Sold to Patients cost center (Account 7710), and the related revenue must be reflected in the Drugs Sold to Patients revenue center (Account 4710)..."

Do inconsistencies in reporting result in data that is "materially flawed" for purposes of analysis?

There is no data readily available to quantify the statistical effect of the accounting inconsistencies related to chargeable supplies and pharmaceuticals. Intuitively the misclassified revenue and expense is probably not material enough to affect public policy. Revenue and expense totals would be correct. The misclassified revenue *would* affect user comparisons of revenue by department.

Is there a matching problem of revenue and expenses caused by the revenue for supplies and pharmaceuticals being reported in multiple departments?

The OSHPD reporting manual section 1100 requires the matching of revenue and expenses by accounting period. This concept of matching does not appear to apply to recording revenue and the related expense in the same department. However, for analysis of profit by functional department, the revenue and cost of items need to be in the same department. Hospitals that report supplies and pharmaceutical revenues charged to patients in multiple departments usually re-

port the related expense in the same multiple departments. This would help retain the reasonableness of the profit analysis by department. However, an analysis of data by users will be flawed if they rely on the manual instructions and assume all chargeable supplies and pharmaceuticals are reported the Medical Supplies Charged to Patients and Drugs Sold to Patients departments.

Is there a valid reason for hospital failure to account for the data as outlined in the OSHPD manual?

Often departments such as surgery, emergency, oncology or radiation therapy handle supplies and pharmaceuticals, and charge patients for both the handling and item itself. These supplies and pharmaceuticals may be directly dispensed by the departments rather than ordered from the Central Supply or Pharmacy departments. It therefore makes sense under a responsibility accounting system for the department performing the service or making the product available to also receive credit for the charged revenue and account for the expense. Of course, this does not make sense in a functional accounting system.

Can the inconsistency be remedied by reclassifying revenue and expenses after the fiscal year end, or must the OSHPD accounting procedures be followed for consistency?

The revenue and expense can be determined after the fiscal year end and reclassified *in toto*. The revenue for supplies and pharmaceuticals charged through various departments often can be accumulated through the hospital's revenue by charge code reports. The billed charges have the same revenue code identifiers, but different charge code numbers. If there are a number of charge code numbers, the accumulation of revenue can become a large task. Also, the breakdown of the revenue by charge code by payer category is not always available—making estimates necessary. Therefore, a revenue reclassification may be both time-consuming and sometimes inaccurate. The expense of chargeable supplies and pharmaceuticals in surgery, etc. can be accumulated in the chargeable subaccounts. However, in some cases, the distinction between chargeable and nonchargeable supplies is not always maintained by the hospital. Thus, there are two problems with making the reclassifications—the need to run special reports that are often voluminous and the accuracy of the information that can be obtained.

POINTS TO ADDRESS:

Is product line cost accounting more representative of data users needs?

The emphasis on reporting costs has progressively been changing from functional accounting to product line accounting. This can be seen by the extensive use of discharge data reporting in the industry today. Discharge data reporting is now limited to charges and statistics. At some time in the future costs may also be accumulated by procedure. In general, hospitals still do not have a product line cost systems in place. Some states such as Massachusetts have used cost to charge ratios to convert procedural charge data to costs.

Hospitals for the most part are using product line accounting to evaluate contracts with specific payers. Most hospitals that maintain product line accounting also maintain responsibility accounting for management reasons. With this in mind, an evaluation should be made as to whether both functional and product line cost accounting could be maintained as more hospitals develop product line accounting.

The fundamental question is whether the need for hospital comparative data outweighs the needs of hospital management.

As shown in the example above, the reality of hospital operations and management needs appear to have overshadowed the OSHPD reporting requirements. Without knowing which hospitals report correctly (per OSHPD instructions), it is uncertain whether there is comparability in any data when the needs of either responsibility accounting or product line cost accounting outweigh the needs of functional accounting.

Standard Units of Measure

ISSUE:

Are the OSHPD standard units of measure, as prescribed by the OSHPD uniform accounting and reporting system, appropriate for measuring utilization and for comparing revenue and cost per unit?

WHY THIS IS AN ISSUE:

OSHPD requires hospitals to maintain and provide uniform statistics for measuring utilization and for comparing revenue and cost per unit. As specified in the OSHPD Accounting and Reporting Manual, standard units of measure for revenue-producing cost centers were developed to measure the volume of services provided to patients by a cost center and to compare cost efficiency. Standard units of measure for non-revenue producing cost centers were developed to compare cost efficiency and, in some cases, to measure the volume of support services rendered to patient care cost centers.

However, the question is whether the purpose specified in the Manual remains a valid reason for gathering this information. Perhaps the more useful purpose is to compare the costs of providing similar services between hospitals by creating a uniform measurement. In addition there are concerns over the gathering and reporting of the standard units of measure. These concerns relate to the accuracy of the statistics, and to the burdens associated with maintaining and collecting them.

POINTS TO ADDRESS:

Do OSHPD's standard units of measure provide a direct correlation to department volumes?

For the most part the answer would be yes. However, this does not mean that in some cases an alternative statistic may not offer a better correlation. The standard units of measure are categorized by the following cost center groups:

Revenue Producing Departments:

- Daily Hospital Services
- Ambulatory Services
- Ancillary Services

Non-Revenue Producing Departments:

- Research Costs
- Education Costs
- General Services
- Fiscal Services

- Administrative Services
- Unassigned Costs

The units of service for routine departments are patient days, which is a statistic routinely captured and understood. In the ambulatory services area, the most common statistic is the number of visits. The number of visits is a measure of volume; however, it does not do well as a measure the actual amount of service provided. An emergency service patient with a simple laceration does not require the same amount of service as an auto accident victim with multiple body system injuries. OSHPD also uses these statistics to calculate gross revenue unit of service and direct expense per unit of service for each cost center, and to compare these figures between hospitals to show differences in charges and economic efficiency.

The ancillary services area also uses standard statistics that primarily measure the volume, but not the intensity, of services provided. Those services that use relative value units, such as Radiology-Diagnostic, were developed to capture the volume of services while factoring in the complexity of the services. Durable medical equipment uses adjusted inpatient days as the statistic, which doesn't tell anything about the amount of durable medical equipment provided. While most data users would agree that a weighted statistic provides more meaningful information, its accuracy may be questioned due to more difficult data collection requirements and a tendency to collect the "simpler" statistic.

The non-revenue producing department statistics are similar. Some of the statistics provide an indication of the volume of services provided, but the majority does not. Examples of such statistics include pounds of laundry or the number of patient meals. Other statistics do not correlate well to the volume of service and were developed primarily for cost accounting purposes. For example the Security statistic is the number of hospital FTE (full time equivalent) employees. This describes how many people are served by Security but does not represent the amount of security service provided. Thus, the Security statistic would be the same whether there was 2 staff providing security or 22. However, the Security cost per hospital FTE would be 11 times higher or lower.

Patient Accounting is another instance in which the statistic used bears only a modest relationship to the volume of service. The statistic in this case is $1,000 of gross patient revenue. One might expect that as the volume of revenue increases, the amount of patient accounting services would increase. This is true to some extent; however, a 5% increase in charges would increase this statistic by 5% even if the Patient Accounting activity changes not at all. Similarly, the amount of activity would vary in Patient Accounting depending upon the mix of services. If two hospitals had the same total patient revenue but one hospital was a tertiary care hospital and the other had a very high outpatient volume, the Patient Accounting volume would likely to be greater at the hospital with the high outpatient volume because of the number of separate bills.

Accordingly, even though many of the units of measure statistics do achieve their purpose of indicating volume of services, not all do. Some of the statistics bear only a vague relationship to volume of services while a few do not appear to measure volume at all and are required for cost accounting purposes only.

Do hospitals have any difficulties in collecting and maintaining the required OSHPD standard units of measure? If so, what are the consequences?

Many OSHPD statistics used as Standard Units of Measure are routinely collected by hospitals and are likely to be reasonably accurate. For example, patient days, gross revenue and FTEs are used for hospital management and cost reporting and therefore are routinely collected. Some statistics that hospitals typically maintain are likely to be inaccurate in some instances. For example, "visits" is a required statistic. While this statistic appears straightforward, it is subject to some confusion and misreporting. For example, when a patient is seen in the clinic for a blood pressure reading or a vaccination administered by nursing staff, is this a visit for purposes of OSHPD reporting? This service would not constitute a visit for other purposes such as billing third party payers, or for a rural health clinic where only face-to-face encounters with a provider are considered a visit.

Hospitals have more difficulty in maintaining statistics not used for other management or reporting purposes. For example, the use of minutes for Magnetic Resonance Imaging services or the hours of treatment for renal dialysis is not likely to be captured for purposes other than OSHPD reports. Other statistics such as relative values units for radiology and cardiology services are not commonly used in hospitals. When reporting to OSHPD, these hospitals might convert their collected statistics, such as the number of x-rays or procedures, to relative value units by using some conversion factor. The data user is unaware that the reported statistics are estimates.

A statistic not used for management or other hospital purposes is unlikely to have as many resources dedicated to its collection as one used for multiple purposes. Uncommon statistics such as relative values units for radiology are an example of a statistic that is difficult to collect and oftentimes of questionable accuracy. For rural and smaller hospitals, implementing a data collection system requires the use of database which cross-references CPT procedure codes to relative values. Unless this table is already included in the hospital's computer system, this requires coding of large numbers of procedures. Given the resources available to these hospitals, it is unlikely that this will be done consistently and accurately. Thus, the question is whether reported relative value units are accurate for a number of hospitals. Even for larger hospitals, statistics such as relative value units are often not routinely collected.

Because hospitals have difficulties collecting the statistics for some departments, their data is unlikely to be accurate. This means that comparisons of hospital departments on the basis of volumes are inaccurate.

Should simplicity and accuracy outweigh the need for departmental statistical correlation?

First of all, the needs of the data users must be considered. If most data users are concerned with volume–of services rendered or performing revenue/expense per unit comparisons—the current types of statistics should be maintained and improved. As demonstrated, a number of the current statistics do not correlate well to the volume of service provided by the department. Thus, the goal of measuring volume through the statistics is not always met and, in some cases, not intended. Even if the department correlation concerning volume of service is paramount, there is a need to examine the statistics to ensure they appropriately balance relevance, accuracy and reporting burden. It may be that simplicity and accuracy should outweigh the need for correlation to departmental volumes.

It also appears that for many data users, the key comparisons are expense per unit of service. For example, many hospitals compare themselves and their individual departments to their peers by looking at the cost per adjusted patient day or another easily understood and collected statistic. Their concern is not whether radiology's relative value units are twice as much as another hospital's but what is radiology costing on an adjusted patient day. By looking at the data for hospitals similar to their own, they effectively adjust for the complexity of the services rendered in radiology. If data users' needs are primarily of this type, then simplicity and accuracy appear to be the most important consideration.

Whether the data user is reviewing hospital volumes by department or comparing expenses of several hospitals, it appears that simplicity and accuracy are key. If the statistics are simple to collect, they are more likely to be accurate and thereby be useful to the data user. Complex or unusual statistics, even if seemingly more accurate than a simple count, but will be more difficult for hospitals to maintain. Thus, there will be greater chances for error and less reliance can be placed on the data. Regardless of the data user's emphasis, it appears that there is a need to review these statistics to clearly determine their purpose and develop statistics that will be reasonably accurate without unduly burdening hospitals

Other Issues

Combined Medi-Cal/OSHPD Disclosure Report Audit Function

Beginning in 1984 OSHPD established a random field auditing process through a contractual arrangement with the Medi-Cal Audit Review and Analysis section of the Department of Health Services (DHS). Approximately 40 hospitals and 40 free standing long-term care facilities per year are audited at an annual cost of $250,000 to OSHPD.

OSHPD provides DHS with a seven-page audit program to follow. Each item on the audit program identifies whether the hospital meets or does not meet the OSHPD requirements. The auditor is to provide comments on those items that do not meet the requirements and indicate whether or not the hospital agrees with their findings.

The audit program is comprised of the following components:

- Issues related to whether or not the hospital is following the OSHPD uniform chart of accounts, and related accounting system.
- Verification of hospital accounting records (e.g. general ledger) with data reported on the hospital's disclosure report.
- Verification that documentation exists to support the reported statistics, related to the annual reporting of both utilization and allocation statistics.
- In-depth cost center analysis and review of annual reported data to verify the accuracy of related standard units of measure, revenues, expenses and payroll related data.
- Review of information reported on the OSHPD quarterly reports, including the accurate accounting and reporting of charity care, tobacco tax funds, Medi-Cal disproportionate share payments, and specified revenue, expense and contractual allowance information.

In the interview with OSHPD staff involved with DHS in the auditing process, there was concern as to whether contracting with DHS to provide this function was the most efficient use of OSHPD resources. The objective of the audit function is to further the efforts to achieve uniform reporting by assuring that hospitals are following the uniform accounting system. However, DHS' audit function is primarily focused on Medi-Cal reimbursement principles and payments to ensure that DHS is only paying hospitals at appropriate reimbursement levels. Without being focused on OSHPD accounting and reporting principles can DHS provide adequate and experienced resources, and establish appropriate priorities to accomplish OSHPD objectives?

Interviews with hospitals have suggested that the joint Medi-Cal/OSHPD audit is not working satisfactorily. Most hospitals felt that the audit was not a useful process and that the Medi-Cal auditor did not treat the OSHPD portion of the audit as a priority. They commented that as a whole, the Medi-Cal auditors were

not helpful in responding to questions regarding the OSHPD accounting system, and seemed to lack familiarity with how it works. It appeared that the auditor's lack of experience with the OSHPD system limited their capabilities to only balancing numbers.

The issue that needs to be addressed is whether OSHPD could spend the $250,000 that is currently being allocated to the DHS auditing contractual arrangement differently to further the efforts of achieving uniform reporting. Alternatives include the establishment of an internal field auditing staff within OSHPD, expanding the role of the existing OSHPD desk auditing staff to include a field audit function, contracting with another outside organization to perform the auditing function, either from within state government or with a private auditing firm, or provide more on-going educational training to hospitals.

Accounting for Services Related to Alternative Birthing Centers

Hospitals are having difficulty in accurately separating the costs of OB (post partum), Alternate Birthing Center (ABC), Labor & Delivery, and Nursery costs when the same management and staff are used for all three services.

The trend in maternity care has been to erase the lines between the Delivery, Nursery and post partum care. This can be seen with mothers staying in birthing rooms from delivery to discharge and well babies being cared for in the mother's rooms. In other cases, the "traditional" form of maternity care still occurs. C-sections might be performed in ABCs, Labor & Delivery, or Surgery & Recovery. This continuum of care causes costs that were historically separated into separate functional cost centers to be commingled. Separating these costs to accommodate functional accounting becomes difficult if not impossible.

The combination of these areas of service may distort common historic grouping comparisons. The groupings include:

- OB—traditionally an inpatient routine floor,
- ABC – Combined OB, Nursery and Delivery using licensed beds on an inpatient routine floor.
- Nursery—considered separately from adult inpatients and not included in bed and day counts, and
- Labor and Delivery—an ancillary area.

The quandary is whether the historic comparison of these cost breakdowns outweighs the change in reality of actual hospital functions. Said another way, do we force costs to be separated when the services have been combined?

Statistics for these services could still be maintained. Hospitals still could count deliveries, and adult and nursery days, if desired.

Accounting and Reporting for Rehabilitation Services

There is an inconsistency in the OSHPD accounting and reporting requirements as they relate to rehabilitation services. Under a functional accounting

system all rehabilitation related services, regardless of where the service is provided or who receives the service, should be accounted for in the rehabilitation department. The OSHPD accounting system does require hospitals to report such services in the Physical Rehabilitation Care department (account # 6440). However, if the rehabilitation services are provided to a pediatric patient they require the revenues, expenses and statistics to be accounted for and reported in the Pediatric Acute department using account number 6295. Accounting for rehabilitation services in the Pediatric Acute department is inconsistent with OSHPD's accounting requirements, which require functional accounting, not responsibility accounting.

Financial Statement Presentation

As a result of our hospital interviews and our meeting with the Division of Health Care Finance and Policy (DHCFP) of the Commonwealth of Massachusetts, we have concerns related to the OSHPD requirements related to the presentation of the hospitals' basic financial statements. The specific statements include the Balance Sheet, Income Statement, Statement of Changes in Equity and the Statement of Cash Flows.

In order to achieve uniformity, and to make all financial information available on a common database, OSHPD established a uniform set of financial statements to be completed by all hospitals. Overall they follow generally accepted accounting principles (GAAP), except with respect to various specified accounting practices. For example, the income statement for OSHPD still includes bad debt as a deduction from revenue rather than an expense item. Also, the OSHPD income statement provides total revenue information along with related revenue deductions rather than only net revenue. These issues themselves are not problems, and in fact actually provide more useful information than would be presented under GAAP.

The common issue during the hospital interviews was converting data from the hospital's actual year-end audited financial statements to the OSHPD uniform reports. Each hospital's actual financial statements followed consistent principles, but actual formats, including specific line items and line descriptions, differed. There are not only differences between the hospitals' presentation formats and OSHPD's formats, but also differences among hospitals. As a result, most of the hospitals that were interviewed indicated that there were issues related to the accuracy of some line items reported on the financial statements. In particular, the most common financial statement where problems occurred was the Cash Flow Statement. A frequent comment was that the Cash Flow Statement should not be part of the OSHPD reporting process, since this statement needs to be current to be useful, and is then usually used as a basis for projection purposes. In addition, unlike the other three basic financial statements, significant information contained in the Cash Flow Statement does not directly tie to other OSHPD reporting forms.

During our meeting with DHCFP in Massachusetts we learned that in addition to filing the uniform report in Massachusetts, hospitals are required to submit a

copy of their audited financial statements. DHCFP has indicated that the notes to the audited financial statements are extremely useful in understanding the data that the hospital is reporting. Medicare and Medi-Cal already require these statements, so this would not be an additional reporting burden. Also, depending upon whether OSHPD's mission and focus is modified (a discussion, which is provided elsewhere in the report); the information contained in the notes to the statements will assist with any analysis work that is performed.

If hospitals were to submit their complete audited financial statements to OSHPD, could copies of this information be provided to data users who request copies of hospital data, without creating a significant cost or workload? Would this provide more insightful, useful information than that which is currently available? And, finally would the elimination of the OSHPD uniform Cash Flow Statement, replaced by audited financial statements, lessen the workload incurred by hospitals in complying with OSHPD's current reporting requirements, while improving the quality of the data that is being reported?

Medi-Cal Disproportionate Share Program

The issue concerning the Medi-Cal disproportionate share program is whether the Office's Accounting and Reporting system adequately account for Medi-Cal disproportionate share payments to government-owned hospitals?

The Medi-Cal program has various supplemental payment programs for hospitals serving a disproportionate share of Medi-Cal and other indigent patients. The most significant of these was established initially by enactment of SB 855 (Chapter 279, Statutes of 1991). In addition, there are four other supplemental payment programs, which result in less payment than under SB 855. In all four cases, the additional payments to hospitals are accounted for as offsets to their Medi-Cal contractual adjustments.

SB 855 payments appear as a separate line item, while the other disproportionate share payments are netted against the Medi-Cal contractual adjustment before they are shown on the Office's disclosure reports. In all cases, the supplemental payments are included in Medi-Cal net patient revenue. This aspect of accounting and reporting has generally not been an issue. However, the accounting and reporting practices required by OSHPD to address the funding of the disproportionate share program have not always been followed in a consistent manner by every hospital for various reasons.

The supplemental payments to hospitals, under SB 855 and three of the other programs, consist of state and federal matching funds. The state share of the payments is funded by transfers from governmental entities that own qualifying hospitals—including counties, healthcare districts and the University of California. These transfers must be sufficient to pay the state share of payments for not only government-owned hospitals but also for the private disproportionate hospitals.

In many instances a transfer is made by the hospital, after it receives the disproportionate share funds, to its government entity. (For most district hospitals, there is only one legal entity.) These transfers are not treated by OSHPD as an

expense or as a reduction of Medi-Cal net patient revenue. Instead they are reported as a voluntary informational item on the quarterly disclosure reports and as a reduction in equity on the Balance Sheet captured through a deduction on the Statement of Changes in Equity (Page 7) of the annual disclosure report.

The governmental hospitals that transfer funds to their related public entity assert that the current reporting does not accurately portray their financial performance. The total disproportionate payments received are included in the facility's net income while transfers to the public entity are not.

In the current competitive marketplace, county and other public hospitals are often seen as just another competitor for market share—at least for insured patients. Thus, data on financial performance are carefully analyzed. The appearance that a government hospital is doing better than it actually is—because disproportionate share payment transfers to the related public entity are not offset—is a reasonable concern of these hospitals. Such data can be used to portray the county hospital as being financially successful, particularly if the county government subsidies are not considered.

One of the major purposes of the Office's reporting requirements is to provide useful information to the public and data users on the performance and activities of hospitals. Therefore, it appears that the current methods of distributing data may need to be modified to clarify practices such as these transfers.

The Office has recognized the misunderstandings that have resulted from this issue and has responded by including the data elements noted above for the quarterly and annual reports. But this may not have resolved the issue to the affected hospitals' satisfaction. The problem is that in comparing net income on the quarterly and annual report, the user must be aware of the additional transfers that have occurred to truly understand the financial position of the facility. Whether most, if any, of the data users have this knowledge is uncertain; and even if they do, the transfer payments may not be accurately reported by the hospital or adjusted by the data user. It is unlikely that researchers not familiar with Medi-Cal's disproportionate share program would have the necessary knowledge to take into account these types of transfers.

The Office's accounting and reporting requirements generally follow GAAP. However, the audited financial statements issued by some CPA firms show the transfer as a reduction of Medi-Cal contractual adjustments rather than as a reduction of the hospital's fund balance. Initial research on the Government Accounting Standards Board (GASB) requirements in this area provides no clear answer of how the transfers should be netted. It appears that an argument could be made that these transfer transactions are quasi-external transactions and should be treated as expenditures. Further research is required for a more definitive answer. In any case, from a data user's perspective, it is essential that all transfer payments be reported, and that sufficient instructions be provided to enable the data user to identify these payments.

Part 3
Interviews with Hospitals and Health Care Systems

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BACKGROUND AND SUMMARY

A cross section of hospitals, based upon size and type of ownership were interviewed as part of this project. Each hospital was selected with input and assistance from the California Healthcare Association (CHA), along with the regional hospital associations and constituency groups that represent various types of hospitals. In addition, CHA, the regional associations and constituency group members were kept apprised of the status of the project on an on-going basis, with their input on issues being solicited.

The cross section of hospitals selected to participate included two district hospitals (one small rural hospital and one larger urban hospital), two not-for-profit Catholic systems, Adventist Health System, one university hospital, one private rural hospital, Kaiser Permanente, one private health system (which included hospitals receiving Medi-Cal disproportionate share payments), two public hospitals, one children's hospital and one private not-for-profit hospital.

Each hospital was asked to provide copies of all financial and utilization reports that they filed during a one-year period. Specifically, reports being requested were those filed on a regular basis, such as annually or quarterly, with any state, federal or private entity (e.g. AHA). Reports filed on a one-time basis for a specific purpose, tax reports, and internal reports were to be excluded. The purpose of collecting this information was to determine the level of redundancy and duplication in reporting that might exist, and to identify those entities that collect hospital financial and utilization information for further follow-up. The earlier chapter in this report that includes the matrix of report requirements was derived through this survey process.

Subsequent to the data reporting survey process, each hospital representative was provided with a package of "issue papers" that described various accounting and reporting requirement issues and areas of potential consolidations in reporting. These are included in an earlier chapter of this report. They were asked to review the "issue papers" for an upcoming interview, and to consider if there were other accounting and reporting issues that needed to be addressed. During the interviews each hospital representative was provided with a summary

of the types of reports that hospitals were being required to submit based upon the initial data request for this project. All confirmed that the listing was complete, as well as the type of issues that were addressed by the "issue papers."

Although a copy of each hospital's actual interview is included in this chapter, a summary of the hospitals' perspective on each issue is listed below.

Annual Utilization Report Consolidation:

- Most required data is no longer relevant
- Reporting on a calendar year versus a hospital's fiscal year is a burden
- Not sure the report is being utilized
- Consolidating specific needed data elements with another OSHPD report makes sense
- Maintaining the necessary data and preparing the report is not a significant burden, except regarding the calendar year issue

Capitation Accounting Methodology:

- Only potential issue relates to accounting for "out-of-plan" expenses
- Current OSHPD methodology is appropriate since hospitals receiving premiums are at risk, therefore, they incur the expense
- Double counting of expenses (for hospital treating the patient and hospital responsible for payment) when performing area wide or statewide analysis is an issue
- Unless purchased inpatient/outpatient services are differentiated between managed care plans and other contractual arrangements this issue cannot be resolved-however, such differentiation may or may not be difficult to determine
- Inform the data users who purchase OSHPD data that this situation exists

Charity/Bad Debt:

- Hospitals divided on requirement for a standard definition
- Those opposed to a standard definition are concerned that standard definition established by the state:
- Would dictate a hospital's mission inappropriately
- Would not meet the community's local needs

- Would require inappropriate auditing
- Would encourage its mis-use by patients
- Claim that the definition is not the problem, it is obtaining the necessary financial supporting documentation from patients
- Those who support a standard definition are concerned that without a standard definition:
- Reimbursement for indigent care is not distributed appropriately
- Data users can not compare the level of charity care being provided between hospitals-there are no meaningful benchmarks
- Hospitals need guidelines
- Most hospital were supportive of exploring an uncompensated care pool approach that followed the type of system being used in Massachusetts, as long as hospitals were not the only contributors-all agreed that a standardized definition of charity care was essential if such a pool were created
- Hospitals divided on whether charity care or bad debt should be differentiated
- Some hospitals suggested that the SB 697 community benefits reporting requirements should be standardized with a data base established to collect the information on the disclosure report

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

- All except one of the hospitals supported a consolidation approach
- Hospitals were split as to which report would be the surviving report
- Those which supported the Medi-Cal cost report as the lead report indicated that the level of detail required by OSHPD led to inaccuracies in reporting and excessive accounting and reporting burdens
- Those which supported the OSHPD disclosure report as the lead report indicated that the lack of detail in the cost report did not provide sufficient information to hospitals and policy makers which utilized the information, nor was it as easily accessible as the OSHPD information
- Hospitals all agreed that the Medi-Cal supplemental worksheets should be eliminated

- Most hospitals would like to see California seek a federal waiver to include the Medicare cost report into the consolidation process
- All agreed that consolidation of some sort was possible and made sense
- Department of Health Services raised numerous issues that would have to be addressed on either approach, however, they were not completely opposed to exploring the concept

Responsibility Accounting (Uniform Accounting):

- The majority of hospitals indicated that the functional uniform accounting system required by OSHPD did not meet with hospital operational or management needs
- Most hospitals indicated that reclassifications and estimates were common practices in meeting the uniform reporting requirements, since they unable to adapt to OSHPD uniform accounting requirements as their sole source of capturing hospital financial information
- Most hospitals indicated that the level of detail required by the OSHPD disclosure report leads to lack of accurate and uniform reporting
- Most agreed that even if uniform accounting is the only way to achieve uniform reporting, hospital operational and management needs will supersede this requirement leading to a lack of uniform reporting anyway
- Most agreed that OSHPD should seek uniform reporting to the best extent possible without requiring uniform accounting-OSHPD would be better off establishing guidelines for uniform reclassifications and estimates-also initiating on-going educational programs
- Regarding the example of the alternative birthing center, the Adventists suggested one cost center with multiple statistics-others that were asked for their input on this issue agreed.

Standard Units of Measure:

- All agreed that in many cases the standard units of measure currently being reported are not uniform-due to differences in definitional interpretation among hospitals, difficulties in capturing the required statistics
- Most agreed that simplifying the statistics would do little to lessen the accuracy of the data being reported, but could lessen the burden to hospitals having to maintain and report the data, as well as in many cases may improve upon the uniformity

- Common comments were that patient days were not a problem, but outpatient visits, RVS units, therapy treatments, MRI minutes, and many support service statistics were the major problems
- When discussing the possibility of establishing a double step-down process to capture the total routine and ambulatory costs per unit, most hospitals did not support the concept if it meant that the current standard units of measure not only would have to be maintained, but maintained by routine and ambulatory department-what is gained versus the burden, and would it be accurate anyway, also is there an alternative

State Controller's Report:

- Only impacts district hospitals directly, and county hospitals indirectly
- District hospitals support consolidating with OSHPD-lessens burden of reporting and eliminates conflicting time requirements
- County hospitals report as part of the total county reporting and would not likely benefit from a consolidation
- State Controller's office is not adverse to exploring this option

Combined Medi-Cal/OSHPD Disclosure Report Audit Function:

- Most hospitals felt that this was not a worthwhile process
- Most felt that if the purpose was to help achieve uniform reporting that there were better ways to accomplish this goal
- Most felt this was not a high priority for Medi-Cal

Reporting of Disproportionate Share Transfers By County Hospitals:

- Only discussed with county hospitals and their representatives
- Agreed that modifying the reporting was not the answer
- Agreed that educating the data user on how the payments were reported was necessary

In addition to the interviews with the individual hospitals, we conducted a group interview of representatives from the California Healthcare Association (CHA) and the regional hospital associations and constituency groups. The results of that interview are also included in this part.

ADVENTIST HEALTH

Contacts: Don Gordon
Director of Budget and Reimbursement

Judy Campbell
Director of Accreditation

Specific Issues

Annual Utilization Report:

Gordon was not familiar with the Annual Utilization Report.

Capitation:

Glendale Adventist Hospital and White Memorial Hospital are the only hospitals in their organization that require accounting for capitated payments. They are not having any problems with OSHPD's guidelines in this area. Gordon indicated that the OSHPD requirements follow both GAAP and the audit guide and therefore changes should not be made. Because hospitals are at risk for ensuring the beneficiary's care, premiums should be reported as an expense to the hospital responsible, regardless of where the care is actually provided.

Charity/Bad Debt:

Do not change OSHPD's current definition of charity care, and continue to allow hospitals to provide charity care consistent with their missions. However, if a definition were to be standardized, starting with the federal poverty guidelines would be acceptable.

Charity should be defined as early as possible in the process and separated from bad debt. If not kept separate there would be no incentive to collect it. From a taxpayer standpoint, a non-profit hospital not paying taxes should truly provide charity care. They would like to see Medicare and/or Medi-Cal shoulder more of the payment burden if they continue to increase hospital responsibilities for providing care, regardless of the patient's ability to pay. This would be better than implementing any uncompensated care pool.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

The cost reports are completed prior to OSHPD reports due to reimbursement implications and due dates. They do not see much efficiency to be gained from consolidating the reports, even if the Medicare cost report were included. They would continue to maintain much of the same information anyway.

Responsibility Accounting/Functional Accounting:

The most important issue regarding the OSHPD accounting and reporting system that they would like to see addressed involves the accounting and reporting of services related to OB (post partum), alternative birthing center (ABC), labor and delivery and nursery costs.

They recommend collapsing each of the departments into one department and maintaining the following statistics.

- Deliveries
- OB patient days
- Labor room patient days, prior to delivery
- Nursery patient days (both for well babies and border babies who stay after the mother is discharged.)
- Level "2" costs/charges should be included with the one department, except if separately licensed. The level "2" statistics should, however, be maintained separately. If an NICU exits, create a separate department as under current OSHPD rules.

The entire uniform accounting concept is not an issue for this hospital. The overall chart of accounts and uniform accounting system meets their needs and is thus not a problem for them.

Standard Units of Measure:

Gordon indicated that hospitals should be able to link RVS tables using CPT codes with the charge master to achieve accurate reporting. As a data user he does need a certain level of detail. He wishes he knew that data are accurate, but assumes they probably are not. Gordon and Campbell favor keeping the status quo.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable

Are there any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports that we have identified?

No

Are there other issues that we need to consider?

No

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Although the OSHPD disclosure report has been audited by Medi-Cal, the audits were usually conducted at their contract hospitals only. The audit experience has not been favorable. They indicated that the auditors lacked knowledge about the OSHPD reporting requirements, as well as the OSHPD program. The auditors also failed to recognize legitimate exceptions that had been previously granted by OSHPD and, therefore, failed to withdraw certain audit deficiencies.

Do you ever obtain information about other hospitals from OSHPD or other State agencies?

Yes, they have obtained following information about other hospitals:

OSHPD Quarterly Report.

- Used for evaluating acquisitions issues since it provides more current information.
- Used in making high-level comparisons of market conditions.

We discussed the concept of linking California's quarterly reporting system to the national monthly reporting system in Colorado. He was interested in having national benchmarks, but not sure if the "price" might be too high in added workload. Also, he noted that most hospitals would probably oppose reporting on a monthly basis.

Annual Disclosure Report. Used for the following ad hoc comparisons:

- Efficiencies in labor and supplies.
- Wage rate analysis among competitors.
- Discharge Data.
- Used for market share analysis.

- Used to define Medicare utilization for supporting sole community provider status.

Are you concerned that your hospital's data is available to others?

No.

Do you have an estimate of time and resources that it takes to provide the data to OSHPD?

Quarterly Report: Half a day per quarter

Calendar Year Utilization Report: Information not available.

Annual Disclosure Report: It takes approximately two weeks without any interruptions, if accounting records have been maintained properly. The least accurate report worksheets include:

- Page 10 – Net revenue per unit by department. Using estimated departmental contractual allowances is inappropriate.
- Financial Statement Issues. The cash flow statement and statement of changes in fund balance should be eliminated from the OSHPD reports. If hard copies of the financial statements are required then the health system may only have system-wide audited financial statements.

Do you have an estimate of the time and resources to provide the data for reporting to other state agencies?

There is an insignificant incremental difference in preparing the Medi-Cal cost report as long as the Medicare cost report is required. He would recommend, however, eliminating the Rate Development Branch worksheets that do take considerable time to complete; the data could be obtained from the OSHPD disclosure reports.

CATHOLIC HEALTHCARE WEST

Contact: Peter Watkins
Senior Reimbursement Analyst

Specific Issues

Annual Utilization Report:

The medical records department completes the Annual Utilization Report for this organization.

There is concern that merging this report with another OSHPD report might increase the workload for completing the consolidated report. He is not sure how data in the Annual Utilization Report are being used. If they are not being used, why merge the data into another reports at all? The answer may be to just eliminate the Annual Utilization Report if its data are not being used.

Capitation:

One approach to capitation accounting is to record "out-of-network" payments to other hospitals below the operations line and include them with "non-operating expenses." This might make sense because there are no utilization statistics related to the hospital that transferred the patient. It would be difficult to determine how much premium revenue should be transferred to "non-operating revenue." However, a portion of the premium would relate to patients that are treated "out-of-network."

There is concern that including "out-of-network" expenses may make it appear that the hospital's cost increased significantly from one period to the next, when in fact "out-of-network expenses" are not in the hospital's control. This could this be misleading to the data user unfamiliar with the way expenses are recorded in the disclosure report. In addition, there are no corresponding statistics for "out-of-network" patients, and this would result in overstated costs per unit.

Capitation has made both risk pools and re-insurance significant accounting issues for hospitals. Should the accounting transactions related to each of these be recorded as part of capitation activity, or of patient care activities?

Charity/Bad Debt:

Watkins does not support a uniform charity definition because of the many complications of qualifying patients for charity care. Different definitions must be applied in various situations. All patients must be treated, whether they have the ability to pay or not, and a hospital should be allowed the flexibility to determine how to meet its mission for providing free care.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

He supports the basic concept of consolidating these two reports. He favors combining the Medi-Cal cost report into the OSHPD disclosure report by:

- Creating items necessary for Medi-Cal purposes.
- Eliminating the Medi-Cal supplemental worksheets.

An additional reason to combine the Medi-Cal cost report into the OSHPD disclosure report is that no Medi-Cal outpatient data are reported on the Medi-Cal cost report, but are on the OSHPD report.

He is not overly concerned over the scope of the Medi-Cal audits; the focus of the audits has been scaled back to address issues unrelated to services provided under the Medi-Cal contract. One of these areas includes reimbursement related to the skilled nursing unit, even though most of their skilled nursing business is Medicare, not Medi-Cal.

Responsibility Accounting/Functional Accounting:

The current uniform accounting requirements are out of step with changing business practices. Hospitals are unique in their operations, and a uniform accounting system is not applicable in all cases. Hospitals are not comparable.

Departments are concerned with their own operations. Outside entities should not dictate how they can manage or measure their operations. The departments shouldn't have to maintain statistics for the sole purpose of reporting, and also maintain other statistics and records for practical internal purposes. This leads to reclassifications and estimates that make the data contained in the uniform reporting suspect.

Standard Units of Measure:

The current statistics are burdensome and frequently inaccurate; they are not used even by those who prepare the reports for internal purposes. He supports the central supplies and pharmacy approach of applying an "adjusted inpatient day." The current problem areas include the reporting of outpatient visits, many of the ancillary services, including RVS units, and various non-revenue producing department statistics. The required OSHPD statistics are not appropriate for internal management purposes.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not Applicable

Are there any other reports submitted by the hospital, other than the OSHPD, Medi-Cal and Controller's Reports that we have identified?

None

Are there other issues that we need to consider?

Watkins has an overall concern with the purpose of the data collection process, and asks the following questions:

- What is the purpose of collecting the information in today's environment?
- What information is being used?
- Who is using the data?
- For what purpose is the data being used and is the purpose legitimate?

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Lawrence Kinser responded to this question in a follow-up call since he had recently participated in such an audit for Methodist Hospital. He indicated that the audit seemed relatively quick and there were not any major problems. There were not many questions and the auditor provided him with some basic findings. The audit addressed the hospital's compliance with the chart of accounts and with the maintenance of various statistics.

Do you ever obtain information about other hospitals from OSHPD or other State agencies?

No

Do you have an estimate of time and resources that it takes to provide the data to OSHPD*?*

Quarterly Report: A special HBO, Inc. report is generated after the books are closed. This report is used to prepare the quarterly data, along with information obtain from the Board of Directors' Report as well as separate reports obtained from the clinics. It takes approximately four hours per quarter for preparation.

Calendar Year Utilization Report: He does not work on this report.

Annual Disclosure Report: The working trial balance is separately generated. The annual disclosure report is prepared at a different time than the annual cost report. Separate labor distributions have to be generated for each report. It takes approximately six weeks of actual work time to complete the report.

Least Accurate/Most Burdensome Worksheets:

- Page 4 – Standard Units of Measure, including service discharges.
- Page 18 – Statistics
- Page 19 – Allocation Statistics
- Pages 21/22 – Is not difficult, but it usually does not tie to the general ledger. It is very tedious to complete.
- Page 5-9 – Adapting internal financial statements to fit into OSHPD work-sheets is difficult. However, they do not know the solution, since they do not receive audited financial statements on an individual hospital basis, only on a regional basis.

Do you have an estimate of time and resources that it takes to provide the data for reporting to other state agencies?

Medi-Cal Cost Report: Time could be saved by eliminating the Medi-Cal cost report, even if the Medicare cost report was still required. It would be difficult to estimate the actual hours saved, however, eliminating the Medi-Cal supplemental worksheets, which are redundant with other reporting requirements, would be of benefit.

CHILDREN'S HOSPITAL OF LOS ANGELES

Contacts: Lannie Tonnu
Vice-President of Finance/CFO

Tricia Cascione
Director of Financial Operations/Controller

Barbara Whorton
Director of Health Information Management

Specific Issues

Annual Utilization Report:

Barbara Whorton, Director of Health Information Management, works with all applicable departments in the hospital to gather required information. She said it takes about three days to collect all of the information and to file the report.

She would like to see the report consolidated or eliminated. They do not use the information, nor do they know what the data are used for.

They are not concerned with any of the information being disclosed.

Capitation:

Capitation accounting does not apply to them.

Charity/Bad Debt:

They would support uniform standards for charity care. Because of the flexibility currently allowed, they do not believe all hospitals are on a "level playing field" when it comes to reimbursement programs associated with provision of charity care.

The use of the federal poverty guidelines would be acceptable. They believe that "cost of living" adjustments could be applied to these standards to resolve any regional disparities.

One problem for all hospitals in qualifying patients for charity care is lack of patient cooperation. They do not know if there is a way to address this issue.

They would like to see OSHPD provide more detailed reporting of charity care on the annual disclosure report, along with prescribed standards, as a replacement for the annual reporting under the SB 697 Community Benefits Reporting. It takes approximately three to four months to compile and report SB 697 data. There are no consistent standards or appropriate guidelines to follow under SB 697. Therefore, comparisons of hospital community benefits cannot be accurate. They noted that charity care reported on the SB 697 report varies dramatically from the amounts reported to OSHPD.

If a uniform charity definition were developed for OSHPD accounting and reporting purposes, various types of specific community benefits could be included in the definition. A study of the various SB 697 reports could be used to establish the definition. For example, Children's Hospital offers programs for transplant patients. While transplant programs are awaiting government approval for coverage purposes (approximately 2 years), services are provided free to Medicare and Medi-Cal patients. This is the type of service that they feel could be included in a charity definition.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

Less than 2% of the hospital's revenue comes from Medicare, and it has a contract for Medi-Cal inpatient services. Therefore, the cost report does not have a significant impact upon reimbursement.

They are concerned about the Medi-Cal audit process. What is the benefit to taxpayers or the Medi-Cal program of annual audits involving two individuals for a period of six to eight weeks? There are usually less than 10 audit adjustments, all of which do not affect reimbursement. Medicare on the other hand usually performs only a desk audit, but at least asks some good questions. Perhaps by filing a consolidated OSHPD/cost report these kinds of audits could be minimized. If Medi-Cal audits must continue, perhaps they could shift their focus to Managed Care Medicaid days, to verify proper credit to the Disproportionate Share Hospital calculation. Currently auditors take Managed Care Medicaid information from insurance companies who have no incentive to make sure data is complete.

They support the consolidating of these two reports. However, they are not sure there is a purpose for filing a cost report, when the OSHPD data is available for policy decisions and the cost report has no reimbursement impact.

As for the two different due dates (including the time allowed for OSHPD extensions), they have no problem with tying a consolidated report to the five month after fiscal year-end due date. They also would support making the OSHPD report the lead report, with additional schedules added (*e.g.*, reclassification and disallowance worksheets) to meet cost reporting needs.

Responsibility Accounting/Functional Accounting:

Children's Hospital has a "Decision Support System" (DSS) that provides the information needed to maintain OSHPD's required functional accounting system, and to produce desired reports at a departmental level, responsibility level, payer level and even a product line accounting level.

The issues related to central supplies/pharmacy, and obstetrics/labor and delivery, are not applicable. They do, however, report pediatric rehabilitation as part of rehabilitation rather than pediatrics.

Standard Units of Measure:

They support the concept of the issue paper and agree the units of measure should be re-evaluated to achieve better uniformity, and to be less burdensome. The central supplies and pharmacy approach are acceptable alternatives.

If a "double step-down" were adopted to measure the complete costs of a specific routine service, the units of measure would have to better relate to the volume of services provided. However, if this additional data reporting format is not established, they would like to see the standard units of measure re-evaluated.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable.

Are there are any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

- The hospital sends a Short/Doyle mental health report to the county. They will send us a copy to evaluate.
- The SB 697 Community Benefits report is unique to each hospital. This was discussed earlier.

Are There Other Issues That We Need To Consider?

No.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

The hospital is completing an OSHPD/Medi-Cal combined audit for the first time since those interviewed have been at the hospital, which is at least eight years.

They have been uncomfortable with the OSHPD portion of the audit, on which little time has been spent. It was assigned to a first time auditor with little knowledge of OSHPD other than a list of general questions provided to the hospital at the end of the fieldwork. The auditors asked no analytical or compliance questions and did not focus on charity or bad debt and how they were being reported.

The hospital will provide us with an approximation of actual time Medi-Cal spent on the OSHPD portion of the audit as soon as the auditing process is complete.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

The marketing department uses OSHPD information from other hospitals to analyze market share and competition. The financial and utilization data is used in conjunction with the discharge data. Most information is obtained through special requests.

They do not use the OSHPD data for benchmarking. Instead they participate with a group of hospitals in a voluntary reporting project.

Are you concerned that your hospital's data is available to others?

They are not concerned that others have access to their data as long as patient confidentiality is maintained. They understand that various payers use this information as part of the rate negotiation process, and have no problem with that. They believe that the value of having the information available offsets any downside.

Do you have an estimate of time and resources that it takes to provide the data to OSHPD?

Quarterly Report: This takes eight hours per quarter, including review of data prior to submission. They use the report internally for management purposes.

They would not be opposed to participating in the Colorado national data bank, and reporting monthly, if there would be value in it. They define value as more timely useful data. They would want assurances that hospitals would be given an opportunity to provide continual input into the data collection process.

They believe current quarterly reports should be expanded to break out expenses by natural classifications. They would also like to see supplies detailed by medical, non-medical and pharmaceuticals.

Calendar Year Utilization Report: These take three days to complete after all data are gathered from applicable departments. Total time to maintain the data in all departments is approximately one month.

Annual Disclosure Report: The entire process utilizing the hospital's Decision Support System is approximately three to five days.

Areas of concern include:

Page 4 (standard units of measure): accuracy and burdensome issues; the example given was educating staff to count all clinic visits.

Pages 21(a) and 22(a) (contract labor hours/dollars): it is burdensome to maintain this information.

They do not have any concerns about why the data is collected.

Do you have an estimate of the time and resources to provide the data to other state agencies?

Cost Reports: They spend about four to five month on all aspects related to the cost report. These can be summarized as follows:

30% — Collecting information

20% — Preparing the reports

50% — Audit process (including Business Office)

COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA

Contact: Roger Yost
Budget Coordinator

Specific Issues

Annual Utilization Report:

Yost believes the Annual Utilization Report is the easier report to complete; however, he supports merging it into the OSHPD Annual Disclosure Report if the current workload for preparing each report is not increased.

The only additional work related to the preparation of the Annual Utilization Report, beyond the record keeping that would occur for internal management purposes, involves the bed classifications and utilization information reported on page 8. The internal records have to be modified to meet these reporting requirements.

The data reported on the other pages of the Annual Utilization report is maintained by various departments at the hospital. He is not sure how the individual workload of each department is affected by these reporting requirements.

Capitation:

Not applicable.

Charity/Bad Debt:

He states that a standardized across-the-board definition would make sense. Otherwise meaningful benchmarks would not be possible.

He questions whether bad debt and charity should be differentiated. The hospital is going to provide services no matter whether the patient is unable or unwilling to pay.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

This is a contract hospital.

Yost supports the idea of consolidating the Medi-Cal cost report with the OSHPD disclosure report, which would save considerable time for this hospital. The OSHPD report is now completed first, with schedules sent to the reimbursement section for use in preparing the Medi-Cal cost report. Although he favors a consolidated report, he believes high-level data, at the "macro level," is all that is really useful

He would also like to see the Medicare cost report included in the consolidation, perhaps through a demonstration project.

Responsibility Accounting/Functional Accounting:

This hospital maintains an OSHPD chart of accounts. However, the OSHPD functional accounting system is not useful for internal management purposes. The hospital, therefore, has to keep additional records to obtain data for their operational needs. They must then make reclassifications and estimates. They are concerned that other hospitals are likely to have the same problem, which could mean that the data reported at the current detailed level to OSHPD may not be as accurate as thought to be. Again, a "macro level" approach could achieve improved accuracy.

Standard Units of Measure:

The hospital actually uses most of the OSHPD standard units of measure for internal management purposes. There is not much problem maintaining the statistics themselves, but more of a problem with how the statistics, as well as revenue and expenses, are grouped. This has resulted in having to artificially combine and/or split departments.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable.

Are there any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports identified?

AHA Voluntary Annual Survey (Health Forum LLC):

It is 16 pages long and takes a day to complete. It is a high level "macro level" reporting of financial and utilization data.

Because the information is reported on nationwide, it is not likely that AHA would consider accepting OSHPD data in its place. The AHA database would

not accommodate it. However, the information contained in the report should be evaluated, and may provide California with some ideas.

Are there other issues that we need to consider?

Once the OSHPD data are finalized and have passed all the edit checks, why are there additional edit questions or support documentation requests? Why not ensure that edit checks contained in the approved "software" systems capture all edit checks? Also, why not clarify all documentation requirements as part of the initial report submission package?

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Not that they are aware of.

Do you ever obtain information about other hospitals from OSHPD or other State agencies?

Yes, they look at 13 different hospitals per quarter. They analyze specific gross indicators, such as length of stay, average cost per case, occupancy rates, etc. This information is used by management to compare Community Hospital of the Monterey Peninsula with its peer hospitals.

Are you concerned that your hospital's data is available to others?

Not concerned.

Do you have an estimate of the time and resources to provide data to OSHPD?

Quarterly Report: Maintaining the required data takes time but it is difficult to estimate. However, the hospital already maintains the required statistics, chart of accounts, and numbering system to comply with the OSHPD accounting system. It takes approximately one day per quarter for actual preparation of the report.

Calendar Year Utilization Report: Preparation time takes approximately two days per quarter.

Annual Disclosure Report: Preparation time is one full month for one FTE.

Most difficult worksheets to prepare include:

Pages 21/22 – Labor distribution, including contract labor.

Pages 5-9 –It is difficult to tie internal financial statements in with audited financial statements.

Do you have an estimate of the time and resources to provide data for other state agencies?

AHA Survey: Approximately one day per year.

Medi-Cal Cost Report: He cannot separate the time for Medicare and Medi-Cal cost reports. The additional workload beyond record keeping for management purposes is approximately 400 hours, plus two to three weeks audit time per year.

FAIRCHILD MEDICAL CENTER

Contact: Jim Kline
Chief Financial Officer

Specific Issues

Annual Utilization Report:

The Annual Utilization Report is not a challenge for Fairchild Medical Center. It would, however, support a consolidation of the annual utilization report and the annual disclosure report even if it meant that a couple of schedules would have to be added to the disclosure report.

One difficulty in completing the Annual Utilization Report has been breaking down ER visits by type of visit.

Reporting either by calendar or fiscal year would not be an issue.

The hospital questions the purpose of the form and wonders if the whole report could be eliminated.

Capitation:

Capitation accounting is not applicable to this hospital.

Kline did point out, however, that both the hospital from which the patient originated and the hospital that ultimately treats the patient incur a cost that should be reported. The solution may be to offset the revenue against the cost for one of the two hospitals.

Charity/Bad Debt:

He was not supportive of state imposed standards for charity care. A framework would be acceptable, but standards need to be developed at the community level. Fairchild's charity guidelines are based on federal poverty guidelines, ad-

justed by a multiplier that takes into consideration the community's financial condition. The multiplier is developed with input from community leaders. An important consideration is to establish a charity policy that ensures those really in need receive free care, but does not lead to abuses.

An uncompensated care pool with funding from sources beyond just hospitals would be supported. However, such a system is probably not politically feasible. In addition, such a "free care" pool would likely be overwhelming to administer. A common and consistent definition of charity care would be necessary if such a system were developed. Using the amount of charity care to measure reimbursement of indigent care is not an ideal vehicle; however, Kline was not sure if another alternative exists. If charity care has to be the vehicle, then perhaps stronger auditing of charity and bad debts needs to occur.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

The hospital would support the concept of a consolidated OSHPD annual disclosure report and Medi-Cal cost report. Such an approach should combine the OSHPD report into the Medi-Cal cost report, and provide information at the "macro" level.

The OSHPD report provides too much detail that leads to inaccuracies and lack of comparability. The more detail required, the more difficult the report it is to complete; that in turn leads to the use of estimates that result in suspect data. For example, Medicare and Medi-Cal revenue reported on the OSHPD disclosure report by department is based upon the hospital's revenue distribution. However, the actual revenue by payer as reported on the cost report, based upon actual Medicare and Medi-Cal eligibility, will never match revenues reported on the OSHPD report due to patient reclassifications.

If the OSHPD report and Medi-Cal cost report is not combined, then the OSHPD disclosure annual report should be simplified to a level close to that of the OSHPD quarterly report.

One additional issue related to the Medi-Cal cost report audit process and the state resources used to audit their small hospital. The facility was audited for three to five weeks annually and most of the audit adjustments related to settlement data. Such data are based on the year-end paid claims summary that could be reviewed at the auditor's office in a relatively short period of time.

Responsibility Accounting/Functional Accounting:

OSHPD should not dictate a uniform accounting system. Numerous extensive reclassifications must be made to meet current reporting requirements. This leads to a lack of accuracy and is not realistic.

The functional accounting system is a burden that does not meet a hospital's management needs. Salary and hour reclassifications to comply with reporting rules require individual staff to track time between the multiple departments being served. This detail in reporting requirements leads to inaccuracies. Each hospital's accounting system should be based upon its organizational structures, which will not be uniform.

As stated previously, the accounting/reporting should be at a "macro" level; gathering data for the sole purpose of meeting a reporting requirement is burdensome and may therefore not be reliable. Reporting data at the current "micro" level leads individual data users to believe that the more detailed a report the more accurate it will be. This is not true.

Standard Units of Measure:

Kline would support developing simpler standard units of measure, similar to the current approach used for medical supplies and drugs ("adjusted inpatient days"). The problem with an approach using revenue as part of the measure, such as with "adjusted inpatient days," is that each hospital's charge master, the basis from which revenue is generated, is unique. However, if the sole purpose of standard units of measure is to generate comparable departmental costs or revenues per unit in a simplified manner, this approach would be acceptable.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable.

Are there are any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

None

Are there other issues that we need to consider?

Understanding the hospital's operations *in toto*. The financial and utilization reports do not provide a complete picture of the hospital's operations. Other data sources that should be used in conjunction with this data include the OSHPD discharge data and the Medicare and Medi-Cal paid claims summaries. We might want to consider using the OSHPD disclosure reports for financial information (at the "macro" level) and the OSHPD discharge data for clinical data and

necessary statistical data. The Medicare and Medi-Cal payment summaries would provide the majority of the payment information. Developing a reporting mechanism that takes this concept into consideration might be a more useful approach than the current fragmented system. The OSHPD discharge data is not currently timely enough to accomplish this objective. However, more up front edits might address this issue. Hospitals continue to streamline to reduce costs due to reduced reimbursement. It would be helpful to be able to reduce unnecessary reporting to save costs.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Kline had an OSHPD annual disclosure report audited by Medi-Cal while employed at San Joaquin General Hospital.

It was not a good experience. The Medi-Cal auditor did not appear to have a very good understanding of the OSHPD worksheets, nor how they were interrelated. The OSHPD audit was performed at the conclusion of the Medi-Cal audit, and took about a week to complete.

The auditor never addressed any significant issues and mainly spent time tying out numbers. The auditor did not provide any helpful suggestions.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

The hospital uses hard copy versions of other hospitals' annual OSHPD disclosure reports. These reports are used to evaluate profitability, salary data, charity amounts, and departmental or service evaluations.

Are you concerned that your hospital's data is available to others?

No

Do you have an estimate of the time and resources to provide the data to OSHPD?

Quarterly Report: It takes approximately a half-day of preparation per quarter. This information is already maintained for management use.

Calendar Year Utilization Report: It takes approximately a day to prepare this report. This information is already maintained for management use, except for the ER visit breakdown.

Annual Disclosure Report:

Areas of concern:

Pages 21 and 22 are difficult to prepare correctly. These pages require significant reclassifications to meet reporting requirements.

Page 19: Cost Allocation Statistics

Page 4: Standard Units of Measure. Some specific problems include the reporting of transfer discharges, and the allocation of utilization statistics among payers where required.

Pages 5 – 9: Not difficult at Fairchild, but were difficult to prepare at San Joaquin General Hospital. The problem related to the specific detail required by OSHPD that did not fit the type of detail needed by San Joaquin General Hospital.

The hospital estimates approximately four hours a month are spent gathering and organizing information for the disclosure report. In addition, it takes approximately two to three weeks of preparation time, making schedules, collecting departmental data and preparing reclassifications, etc., to organize the data for those who complete the disclosure report. There is then a cost of about $5,000 for the actual preparation of the report that is paid to an outside consultant.

Do you have an estimate of time and resources that it takes to provide the data for reporting to other state agencies?

Medi-Cal Cost Report:

Collecting information: Approximately three hours a month are devoted to logging specific Medicare and Medi-Cal payment information.

Preparing the cost report: It takes approximately two weeks a year to organize information for the outside cost report preparer. In addition, there is a cost of about $5,000 for the actual preparation.

Audit process: Approximately two to three weeks of hospital time are spent on all aspects of the Medi-Cal cost report audit.

KAISER PERMANENTE-NORTHERN REGION

Contacts: Elaine Schweitzer
Director, Medicare Finance

John Mosher
Director, Medicare Revenue Membership Analysis

Allan Redmond
Senior Reimbursement Analyst

Specific Issues

Annual Utilization Report:

The annual Utilization Report is submitted individually by each hospital with assistance from the regional office. They do not have a problem retrieving necessary information and preparing the report. However, they would be support combining this report with another OSHPD report to achieve efficiencies.

Capitation:

The Kaiser Health Plan, not the individual hospital, covers the cost of the "Out-of-Plan" services. Because the health plan is responsible for ensuring the services are available, costs are not included on the individual's hospital's books.

All capitated premiums received are only reported on the health plan's books. As a result, the northern and southern regions each file Health Plan and Hospital consolidated financial statements that reflect the collected premiums. The premiums are allocated to each hospital under a contractual arrangement.

The costs of providing hospital services on-site by the hospitals to both members and non-members are included on a hospital's books and reported as expenses to OSHPD.

Comments on the overall capitation issue:

- Revenue and expenses should be left as currently required by OSHPD. Otherwise there will be a misrepresentation of the actual revenue stream and actual expenses incurred by each hospital. It's a matter of the individual hospital perspective versus total statewide or area perspective.
- OSHPD should define and require separate reporting of revenues and expenses related to outside patient care, and those related to contractual arrangements.

Charity/Bad Debt:

(Note: Virtually all of the following text under charity care was submitted by Kaiser Permanente in writing.)

Is there a need to assure that hospitals accurately report charity care and bad debt?

To the extent that hospitals are eligible for state or federal financial aid based on the level of charity care provided, it is important that this be reported accurately. It is important to recognize that distinguishing between charity care and bad debt involves administrative time and expensive information systems that take resources away from the hospitals' primary mission of caring for patients. In addition, determining if a person is eligible for "charity care" involves some preservice determinations of financial need which may be embarrassing for the patient and which get in the way of providing timely care.

Charity care is one type of benefit provided to the community by hospitals, but it is not the only benefit and perhaps not even the most significant and valuable benefit. It is important that any requirement to report charity care, as distinguished from bad debt, consider the burden on the hospital and on the patient of an additional administrative process, and the broad spectrum of community benefit other than charity care provided to the community by the hospital. Hospitals also engage in research, community health education, and health care outreach that improve health in their communities. Such efforts should not be stifled by a rigid reliance on "charity care" as the primary measure of community benefit. Kaiser Permanente's hospitals conduct, promote and encourage educational and scientific research in medicine and related sciences, educate and train medical students, physicians and other health care professionals. They support a significant level of other charitable, scientific, educational and hospital endeavors appropriate to the communities served, described in our annual SB 697 report to OSHPD. Kaiser Permanente's hospitals provide a significant level of inpatient care and other hospital services to members of our Dues Subsidy Program, which provides free or highly subsidized comprehensive health care coverage to

low income persons who are not eligible for any private or publicly financed coverage.

As a prepaid health care delivery system, we do not track individual utilization in our hospitals in the same detailed manner as a fee-for-service system. Over 95% of the patients we serve are members of Kaiser Permanente who have prepaid for all the hospital services they will be provided through their monthly dues. It would be a particular burden for our system, without any balancing benefit to OSHPD or to the residents of the state, to require us to implement a detailed, burdensome, expensive system to track the financial status of less than 5% of our patients.

What are the impediments to more accurately reporting charity care data?

In addition to the impediments identified in your paper, there is the additional administrative time that must be spent to determine in advance if a patient is eligible for charity care, and the data systems necessary to track the value of the care provided to that patient. This is particularly an issue within the Kaiser Permanente hospitals, which are part of a prepaid health care delivery system. Since we generally do not track individual utilization in our hospitals in the same detailed manner as a fee-for-service system, being required to develop a system to do so would be extremely expensive and represent a significant change in our internal hospital administration.

We should also take into consideration the difficulty of introducing additional financial questioning of patients to determine their eligibility for charity care. Many of these patients will be presenting in the emergency department with serious medical conditions. We need to be careful not to add more stress onto the patient at that delicate time.

Does the importance of accurate data outweigh the cost to the hospitals to produce the data?

The issue here is less the importance of "accurate" data than of "uniform" data. At Kaiser Permanente, we can provide "accurate data" for our system, but it might not be based on similar data provided by another hospital. We are a prepaid health care delivery system with 25 licensed hospitals in California. Each of our licensed hospitals operates an emergency room providing medical care to the community without regard to ability to pay. As mentioned above, we do not track the value of the services provided to patients in our hospitals, whether they are members or nonmembers, in the same level of detail as a fee-for-service provider. Instead, we have financial aid programs that assist low-

income persons who cannot afford health care coverage with access to health care services. Our Dues Subsidy Program provides comprehensive Kaiser Permanente coverage, including full coverage for inpatient and other hospital services, to over 13,000 Californians not otherwise eligible for coverage, on a free or very low cost basis. In addition, for low-income members and nonmembers, we offer our Medical Financial Assistance Program to help defray all or part of the cost of healthcare services and supplies on a nonrecurring basis. In the case of members, this might be a forgiven copayment if they cannot afford it, or free prescription drugs if they do not have prescription drug coverage. For nonmembers, it might be the provision of medically necessary hospital or non-hospital services at no charge. Because we do not track things in the same manner as a fee-for-service hospital, our data would be "accurate" but it would not be "uniform" with the data provided by another hospital. And, we do not believe it is worthwhile to require us to report charity care data in the same manner as another hospital because it would require expenditures of time and money without a significant improvement in benefit to the community.

Are there differences in the treatment of charity and bad debt patients so that the distinction is important to the patient?

Quality health care services, appropriate to the patient's need and good medical practice, should be delivered to the patient in a cost-effective manner regardless of the patient's financial status. The only distinction should be whether or not the patient is billed subsequent to the treatment being provided. A patient eligible for "charity care" would not be billed. However, this should not be at all relevant in the medical care provided to the patient who is using the hospital's services.

Should there be a definition of charity to which all hospitals must adhere? Should there be a standard process for identifying charity care?

Hospitals should be able to establish policies concerning charity care that are consistent with their operating structure. As we discuss above, Kaiser Permanente is a prepaid health care delivery system able to provide "charity care" in ways very different from the manner of a fee-for-service hospital. Our Dues Subsidy Program, described above, and other community benefit programs are designed to complement our comprehensive approach to medical care and the improvement of health in the communities we serve. Mandating that we collect information on charity care in a manner consistent with the way it is collected in a fee-for-service hospital would drain resources from existing, effective programs to provide free and low cost care to low income California residents. And, it

would freeze creative approaches to providing free or low cost medical care to the community at large.

It is also important to recognize that "charity care" is only one aspect of community benefit provided by a hospital. Hospitals also engage in research, community health education, and health care outreach that improve health in the communities they serve. Such efforts should not be stifled by a rigid reliance on "charity care" as the primary measure of community benefit.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

They believe that moving away from using forms designed by the federal government makes sense because state and federal reimbursement programs are continuing to move further apart.

They support the basic concept of consolidating reports. However, they believe it would be better to make a “true” consolidation by actually eliminating redundancies. (Currently, the Medi-Cal cost report requires the work of one person for two weeks above and beyond the time needed for Medicare cost report. In addition, the OSHPD disclosure report is a separate filing.)

Exploring the possibilities of a federal waiver from the “HCFA Form 2552” Medicare cost report in favor of a California’s consolidated report would be a worthwhile exercise. This would go far in achieving the efficiencies that could be gained by a consolidation.

If Medicare won’t go along, then it would probably make sense to merge the OSHPD report into the Medi-Cal report. Additional data could be captured on the cost report to provide the necessary data for health policy analysis.

Responsibility Accounting/Functional Accounting:

Functional accounting is almost impossible. Too many patients cross over to multiple departments of the hospital and cannot be tracked on a type of service basis. This would require the use of numerous reclassifications and estimates. Responsibility accounting is more practical from an operational standpoint.

Both the central supplies/pharmacy and labor and delivery examples in the issue paper are definitely problems.

Each hospital is likely to convert from responsibility accounting to functional accounting in a different manner. It might be incorrect to assume the current functional accounting system results in a uniform reporting system.

Their recommendation is that we not require uniform accounting to achieve uniform reporting. OSHPD should allow hospitals to use the accounting system

that best fits their operational and management needs and make reclassifications and estimates as necessary for reporting.

Standard Units of Measure:

Kaiser does report these statistics. They did not indicate any significant problems.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable

Are there any reports submitted by Kaiser other than the OSHPD, Medi-Cal and Controller's Reports?

No

Are there other issues that we need to consider?

Kaiser Permanente believes that the current exemptions and modifications for Kaiser Foundation Hospitals that are in place regarding the OSHPD uniform accounting and disclosure reporting are essential due to the unique, integrated health care system and organizational structure in which they operate.

Discussion of Kaiser Permanente's unique, integrated organizational structure:

Kaiser Permanente is comprised of three distinct, separate legal, but operationally integrated, organizations:

- Kaiser Foundation Health Plan, Inc. (KFHP);
- Kaiser Foundation Hospitals (KFH), with 14 hospitals in northern California and 10 hospitals in southern California;
- The medical groups: The Permanente Medical Group (TPMG) in northern California and Southern California Permanente Medical Group (SCPMG) in southern California; or collectively PMGs.

In California, KFH and KFHP function in both the north and south while the PMGs operate as stated above. Collectively, the organizations are known as Kaiser Permanente (KP). In the KP organization, almost all of the revenue is received and recorded by KFHP. KFHP provides the hospital and professional services required by its members through KFH and the PMGs.

Discussion of KFH's Accounting / General Ledger System and Financial Statements, and Explanation of Why Certain Data or Documents Are Not Available

KP utilizes two accounting and general ledger *systems*, one in the north and one in the south. Each regional (north and south) KFH has its own distinct and separate general ledger/trial balance. From these general ledgers, separate financial statements (balance sheets and income statements) are prepared for each regional organization. *Separate financial statements for the individual KFH hospitals, however, are not possible.* The reasons are:

- Balance Sheet:

  1. In the KFH general ledger, most asset accounts cannot be identified by individual hospital. About the only asset accounts recorded by individual hospital are the fixed assets. Information regarding fixed assets is reported to OSHPD, where required, by each hospital.

  2. All liability accounts are recorded only at the KFH regional level. They cannot be identified by individual hospital.

  3. All net worth accounts are recorded only at the KFH regional level. They cannot be identified by individual hospital.

  Additions and reductions to net worth cannot be identified by individual hospital because income statements cannot be produced for each hospital. (See below.)

- Income Statement:

  - A. Revenues:

    1. KFH receives its operating revenue from KFHP, under a contractual agreement, in order to provide hospital inpatient and outpatient services to enrolled KFHP members as specified by the Health Plan benefits contracts. This revenue is not based upon, nor identifiable to, actual services provided to individual patients by KFH.

    2. OSHPD requires that revenue be reported in the annual disclosure report:

    - by individual hospital;
    - by "payer type";

- by inpatient or outpatient.

KFH operating revenue is not available in this format.

3. Inasmuch as virtually all the health care services in KFH facilities are provided to KP members, with that care being covered under their KP membership, *bills are not created* for services rendered; therefore, billing data is not collected.

Due to the preceding, it is impossible for KFH to provide the revenue information requested in the OSHPD reports.

- B. Expenses:

The OSHPD disclosure report requires detailed expenses by hospital, by department and by natural classification. Expenses must be recorded at those levels and specifically identified by each hospital. KP expenses applicable to KFH are recorded by all three organizations, KFH, KFHP and the PMGs, requiring extensive multiple allocations. The detail level required by OSHPD is lost through the allocation process, making it impossible for KFH to report expenses according to OSHPD requirements.

Additional Comments:

Kaiser Permanente attempts to provide OSHPD prescribed data to the best of its ability. For example, KP submits the complete required semi-annual discharge data. The portions of the annual disclosure report for which they have data are submitted. KP should be able to provide the required ratios and data for the newly passed nursing staffing legislation.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

No

Do you ever obtain information about other hospitals from OSHPD or other State agencies?

Yes. We review data on other hospitals from the OSHPD reports. As an example, we look at Kaiser costs compared to other hospitals on a per unit basis (*e.g.,* Med/Surg ICU total costs per discharge) to determine areas of potential savings and efficiencies. We obtain both hard copy and electronic versions on a routine basis.

Are you concerned that your hospital's data is available to others?

Overall, no. The only concern is that those who utilize the reports understand the exemptions and exceptions that Kaiser has been granted.

Do you have an estimate of time and resources that it takes to provide the data to OSHPD?

Quarterly Report: Five days are needed per quarter. There are a total of 24 individual hospital reports and two regional reports required and completed in this time frame. (North only)

Calendar Year Utilization Report: We will defer to follow-up discussion.

Annual Disclosure Report: It takes four staff members approximately six weeks to gather and prepare the information, excluding financial statements, for all 24 hospitals and two regional reports. The consolidated financial statements are prepared separately and take additional resources, approximately one week for one person from the National Program Office. This represents the effort for the North report only.

The worksheets that are the most problematic include:

Page 18 statistics – Some of the data elements are difficult to collect.

Page 4 – Service discharges and statistics by payer are difficult to collect.

Pages 5-9 – Only one regional consolidated report is prepared. More information on issues related to this report will be provided in our follow-up discussion. However, the cash flow statements should be eliminated; there is no legitimate purpose or use for including these in the OSHPD schedules.

Do you have an estimate of time and resources that it takes to provide the data for reporting to other state agencies?

Medi-Cal Cost Report: The Medi-Cal cost report cannot be separated from the Medicare cost report, except for Medi-Cal's supplemental worksheet and settlement. The additional workload required for the Medi-Cal cost report is four weeks for one person for all 24 hospitals and two regional cost reports. (North only)

LITTLE COMPANY OF MARY HEALTH SERVICES

Contact: Clyde Evans
Director, Business Services

This not-for-profit Catholic health system has the following components:

- 3 acute care hospitals
- 3 skilled nursing facilities (hospital-based)
- 1 home health agency (hospital-based)

Specific Issues

Annual Utilization Report:

The calendar year filing requirement is a burden because it is not the same as hospital fiscal years. At a minimum the reporting of this information should be aligned with a hospital's fiscal year end.

Regarding some of the specific data elements, there may be difficulties differentiating between intermediate care facility (ICF) and long term care (LTC.)

This report may provide useful information for payers on who is providing what services, at what levels. If it were to be continued, perhaps it could be updated to provide more relevant data. In addition, OSHPD should inform potential data users of the report's availability and how it can be used.

Capitation:

With current hospital financial information systems, the splitting of the detail to avoid the duplicate counting of expenses for "out-of-plan" services is not feasible. Expenses are currently reported on the books of the hospital treating the patient, as well as the hospital responsible for the patient's care. Using the data to determine total costs for a specified area, or on a statewide basis, would re-

quire reducing total expenses by purchased inpatient/outpatient expenses. However, the purchased inpatient/outpatient expenses would have to be separated between costs related to managed care plans versus those incurred as a result of a contractual arrangements. These costs would be difficult to account for.

Alternatively, a disclosure should be made to the data user when purchasing copies of the reports that this issue exists. In summary, the current OSHPD accounting and reporting requirements should be maintained.

Charity/Bad Debt:

Charity determination needs to be independently determined by each hospital. It also should not have to be based solely on patient application, especially if there is an external validation of inability to pay.

Charity should be recognized whenever it best can be determined, not necessarily at the time of service.

Charity should continue to be differentiated from bad debt. It should be based on the hospital's mission and how it informs the public of its availability.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

Evans would support a consolidation of the Medi-Cal Cost Report and the OSHPD Disclosure Report; however, he would like to see the consolidation at a more "macro" level. He would also like the consolidated report to follow the Medicare/Medi-Cal uniform reporting approach.

Responsibility Accounting/Functional Accounting:

He does not prepare the OSHPD reports and thus has no comment.

Standard Units of Measure:

He supports the concept of simplicity as suggested by the issue paper. Some current statistics aren't precise anyway, so not much accuracy is likely to be lost by simplifying the requirement. However, this would require a case-by-case analysis of each statistic. Examples of some specific problem areas include clinic visits and RVS units.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable.

Are any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports that we have identified?

None

Are There Other Issues That We Need To Consider?

No

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

He is not involved in the process.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

He is not personally involved, but is aware that the hospital does obtain OSHPD information at times.

Are you concerned that your hospital's data is available to others?

No

Do you have an estimate of time and resources to provide the data to OSHPD?

Quarterly Report: Not involved in the process.

Calendar Year Utilization Report: Not involved in the process.

Annual Disclosure Report: Not involved in the process

Do you have an estimate of time and resources that it takes to provide the data for reporting to other state agencies?

Not involved in the process.

LOS ANGELES COUNTY RANCHO LOS AMIGOS NATIONAL MEDICAL CENTER

Contacts: Jim Sutton
Controller

Robin Bayus
Budget/Management Reporting

Lupe Martinez
Cost Report Preparation

Alan Wecker
Chief of Fiscal Programs, Los Angeles County Health Agency

Sharon Landry
General Ledger/OSHPD Analyst, Los Angeles County Health Agency

Jin Ng
OSHPD Preparation, Los Angeles County Health Agency

Specific Issues

Annual Utilization Report:

They believe the Annual Utilization Report could be consolidated with the OSHPD Annual Disclosure Report. It would be simple to do and require minor modifications to the Annual Disclosure Report.

If consolidation with the Annual Disclosure Report were to occur, they would no longer have to use estimates to report data on a calendar year basis as they

have to now. They do not see the need for a calendar year report with the type of utilization statistics now required.

Most data elements in the Annual Utilization Report are completed by the administration, with the input of Medical Records. The data are maintained at the department level, and collected and coordinated through finance.

Capitation:

Capitation accounting does not apply to Rancho Los Amigos National Medical Center, but it does to some of the other county hospitals.

From an accounting perspective, the current OSHPD approach is correct, because the hospital is at risk. The problem is counting the expense twice when a patient is treated "out-of-network." Counting the expense by specific hospital can be misleading on a statewide basis. However, the costs on an individual basis should be the overriding factor.

They are also concerned that expenses will be understated overall, as they relate to the disproportionate share cap, if the method of accounting for capitated expenses is changed. There is a need to continue to report using the current methodology from an OBRA – 93 perspective for DSH. One approach to statewide expenses would be to subtract purchased inpatient and outpatient expenses from total operating expenses. This would eliminate the double counting of expenses for treating "out-of-network" patients.

Establishing reserve accounts to take into consideration over or underestimates of capitated payments is an important issue, but it does not affect reporting under the OSHPD system.

Charity/Bad Debt:

They believe charity care should be measured on the basis of costs incurred, not charges. Counties have to treat patients without financial screening. When patients show up at the hospital, they have to be treated.

This is not a definition issue but a patient perception issue. Beyond the definition, it includes how a hospital addresses collecting from the patient. These include policies on who qualifies for free care and what documentation will be required from the patient to support their financial condition. How extensive of an exercise will the collection effort be?

A hospital is unlikely to change policy or mission to meet the accounting and reporting requirements of OSHPD. If a specific definition is imposed, what is reported to OSHPD may not be reflect reality.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

This Medical Center has a Medi-Cal contract; therefore the cost report does not have a significant impact upon reimbursement.

They believe combining the Medi-Cal report into the OSHPD report is the most logical alternative. Timing would not be a problem for this facility because they already submit a report at that time anyway.

The current Medi-Cal audits have been limited to the audit of credit balances and billing issues. An audit will last two to three months, and at times it has been stretched to over a year. This is not the actual working time, but the total time from start and finish. Hospital resources spent responding to the Medi-Cal audit usually depends on the experience of the auditor. Much time would be saved if the same auditor could work with the hospital for a number of years. They do not believe this should pose a problem for a hospital where the impact of audit adjustments is not significant.

As for consolidation of reports, they believe that specific supplemental worksheets can be added to the OSHPD disclosure report for separate reporting of allowable costs versus total costs. Although they believe the most logical approach is to consolidate the Medi-Cal cost report into the OSHPD disclosure report, they are concerned that the OSHPD report may require too much detail, which they believe leads to more inaccurate reporting. Perhaps the two reports could be consolidated with some of the current information reported at a more "macro" level.

Responsibility Accounting/Functional Accounting:

This is an issue for the Medical Center. It follows the uniform functional accounting system only because it is required by OSHPD, and is needed for disclosure reporting and cost reporting purposes.

For internal management purposes the information is reclassified from the functional accounting system to a responsibility accounting system. The Central supplies/pharmacy issue discussed in the issue paper is also a problem for them.

They would like to see hospitals given the flexibility to establish an accounting system that best meets their operational needs. Uniform accounting may be needed for a uniform reporting system, but how "uniform" is the reporting system if hospitals have to make reclassifications and estimates?

The facility does product-line accounting down to the medical service level. In effect, three sets of books must be maintained—functional, responsibility or management, and product-line. They are not sure of the solution to this problem.

How do you meet hospital operational needs and uniform reporting needs? They agree with requiring a uniform chart of accounts and numbering system. However, maybe account definitions should be revisited, as well as the type of reclassifications and estimates that would be acceptable to achieve a uniform reporting system.

Standard Units of Measure:

They support developing more simplified standard units of measure. Statistics are not likely very accurate now. Currently within Los Angeles County, RVS units are measured differently by each hospital. The simpler the statistics the more likely to achieve comparability. They would like the statistics to be based on a cost per day, like supplies and drugs. They agree that revising the statistics in this manner would make it more difficult to arrive at a total cost per day/visit for routine or ambulatory services; however, they question how important it is for the OSHPD report to provide this information.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Los Angeles County submits hospital data to the State Controller's Office based on a combined enterprise fund report that contains more than hospital information. They would like to see hospital data submitted as part of the annual OSHPD disclosure report.

Are there are any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

No

Are There Other Issues That We Need To Consider?

No, all issues were covered.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

The prior year's disclosure report was audited by Medi-Cal. There were some problems with the audit:

- The auditor lacked knowledge of the OSHPD report as well as the OSHPD audit program.
- The auditor did not understand the OSHPD exceptions granted to the hospitals.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

The Medical Center and Los Angeles County use the quarterly and annual disclosure report of other hospitals, as well as the OSHPD discharge data.

Specific uses include:

- Providing comparability analysis at board presentations.
- Monitoring the market place.
- Providing data support under HCFA 1115 waiver.

Are you concerned that your hospital's data is available to others?

They are not concerned with the availability of their hospital data for use by others. In fact, they believe it is of value for raising issues. The only problem is the reporting of the DSH transfer income that provides misleading information and leads to undeserved bad press.

Do you have an estimate of the time and resources to provide the data to OSHPD?

Quarterly Report: The incremental time is about two hours per quarter to capture data not otherwise collected. They would conceptually support data collection that would allow for establishing national benchmarks. However, they do not think that monthly reporting, as required by the Colorado national data bank system, would be necessary. In fact, they believe that monthly reporting is too frequent and doesn't allow meaningful data trends. In other words, one-month comparisons result in data anomalies that would be "smoothed out" over quarterly periods.

Calendar Year Utilization Report: Incremental time to complete this report is not available; the collection of data is spread among too many departments.

Annual Disclosure Report: The time to collect the incremental data that would not otherwise be collected is 311 hours at the hospital level, and an additional 120 hours at the county level.

Most difficult or time consuming:

Page 4 – Standard units of measure.

Pages 21 & 22 – Collection of payroll data.

Pages 5 to 9 – Converting the actual financial statements into the OSHPD disclosure report formats is difficult. They believe that the Statement of Changes in Equity and Cash Flow Statement are not accurate. The purpose of this exercise is to provide for a common database of financial statement information, so perhaps those two statements should be eliminated. The data

user who requests a hard copy of the report could also be provided with a copy of the audited financial statements.

Pages 18 & 19 – It is difficult and time consuming to collect these statistics.

Do you have an estimate of the time and resources to provide the data for reporting to other state agencies?

Medi-Cal Cost Report: It takes approximately 150 hours to collect data and prepare the Medi-Cal cost report. This is information that wouldn't be collected otherwise.

PLUMAS DISTRICT HOSPITAL

Contacts: Mike Barry
Administrator

Marion Gonzalez
Controller

Specific Issues

Annual Utilization Report:

They would like to see the Annual Utilization Report merged with the Annual Disclosure Report. They question why the report has to have all hospitals report for the same period, as opposed to their individual fiscal year, since the disclosure report allows reporting on a fiscal year basis

Capitation:

Not applicable

Charity/Bad Debt:

They believe charity care should have a uniform set of standards, and all hospitals should follow the same guidelines.

Part of the problem is that patients don't always provide the necessary support for their financial condition to qualify for charity care. The patients are then written off as bad debt even though they would have qualified under the charity guidelines.

They are not sure if there should be a differentiation between bad debt and charity care, since both are free care that the hospital is obligated to provide, no matter whether the patients are unable or unwilling to pay.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

They recognize a significant duplication between the OSHPD annual disclosure report and the Medi-Cal cost report. The reports share much of the same data but in different formats.

They would support consolidating the Medi-Cal and OSHPD reports even if the Medicare cost report is not included. By combining the reports, efficiencies could be achieved in processing and reviewing the data at DHS and OSHPD, while saving time and costs at the hospital level.

Responsibility Accounting/Functional Accounting:

The hospital follows the OSHPD uniform accounting requirements. However, there are difficulties as identified in the issue papers.

They have no problems obtaining the information they require for internal management purposes.

Standard Units of Measure:

They have found some of the statistics difficult to capture and would support changing to a simpler "adjusted inpatient day" approach. Even if some of the statistics are needed for internal purposes, they would like to see hospitals given the flexibility to utilize whatever statistics best fit their needs.

State Controller's Report/OSHPD Disclosure Report Consolidation:

They support consolidating the State Controller's Report with the OSHPD Disclosure Report. The OSHPD report would have to be somewhat modified; however most information required on the State Controller's report is already consistent with the OSHPD report.

Are there any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

No

Are there other issues that we need to consider?

The main characteristic to consider when contemplating any change or consolidation in reports is simplicity. The more difficult and the more complex the reports, the greater the chances for errors. Errors could in turn be misinterpreted as fraud.

They also suggest a reduction in the duplication of reporting whenever possible to keep costs down.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

No

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

They do not obtain much information about other hospitals from OSHPD or any other state agency. On occasion, OSHPD Disclosure Reports have been used to compare a competitor's expenses. They once collected discharge data to assist in evaluating an expansion project.

Are you concerned that your hospital's data is available to others?

No

Do you have an estimate of the time and resources to provide the data to OSHPD?

Quarterly Report: It takes four to six hours per quarter to prepare and submit the report. This information is already kept for internal purposes. The concept of monthly reporting may be worth exploring. They are not opposed to monthly reporting simply because it means reporting more often.

Calendar Year Utilization Report: It takes approximately two days to prepare.

Annual Disclosure Report: It takes approximately three days to gather the information for an outside consultant to prepare the report. They are not sure which are the difficult areas, because the consultant prepares the report.

Do you have an estimate of time and resources that it takes to provide the data for reporting to other state agencies?

Medi-Cal Cost Report: It takes the hospital staff approximately three to four days to gather the necessary information for their cost report preparer.

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

Contact: Larry Hinojos
Hospital Fiscal Officer

Kirk Eonsidine
Senior Accountant

Specific Issues

Annual Utilization Report:

They believe the OSHPD Annual Utilization Report could be combined with the OSHPD Annual Disclosure Report.

Reporting on a calendar basis causes problems because of conversion of data from fiscal year to calendar year. These reports should be filed based upon a hospital's fiscal year end, as is the annual disclosure report.

All of the data maintained by the hospital for this report are useful, whether or not the report is required. All data are maintained electronically.

Capitation:

They agree with OSHPD's current accounting methodology that requires a hospital responsible for treating a patient under a capitated plan to record the cost of treating a covered patient in another hospital as an expense. However, they recommend that the expense, which is recorded as purchased inpatient and/or outpatient services, be separated between services provided under a managed care plan and those under another arrangement. This would allow the data user to identify the potential "double counting" of expenses when making area-wide comparisons.

Disproportionate Share Transfer Payments:

They agree with OSHPD's current reporting methodology regarding transfer payments; however, they realize that data users may be confused over interpreting hospital financial statements. Therefore, they recommend that the OSHPD continue its current practices, but provide the data user with an explanation of various reporting issues, such as with transfer payments.

Charity/Bad Debt:

The line between charity and bad debt is ambiguous. If the goal is to provide accurate and consistent information, there is a need to standardize the definition. They support requiring a standardized definition that allows an accurate analysis of charity care provided in other hospitals.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

They need to research this issue further, and will contact us later.

Responsibility Accounting/Functional Accounting:

They provide multiple hospital services in one unit. However, this makes it difficult to prepare reports under a functional accounting system for OSHPD. It increases the workload to the MIS unit that must use a very sophisticated system and the patient bill to capture every cost on a service basis that relates to a patient. This task is almost impossible to do manually. Although they can meet OSHPD's accounting and reporting requirements through this process, they question the accuracy of the data being submitted by other hospitals without the same level of sophistication. They assume the level of accuracy and uniformity in California, with a uniform accounting system in place, is probably no greater then in other states that only require a uniform reporting system.

Standard Units of Measure:

They agree with the need to modify some of the statistics to achieve more uniformity and simplicity. Not all of the statistics need to be modified, but should be reviewed on a case-by-case basis. Specific statistics of concern include visit counts, MRI minutes, FTE's, and Respiratory Therapy treatments. Achieving more uniform statistics by using an adjusted inpatient day approach would not lessen the quality of the information available.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Riverside County submits the report on a countywide level directly to the state. The hospital completes the two pages with hospital specific information.

They do not believe that there would be much benefit to county hospitals in combining these reports.

Are any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

No other reports.

Are there other issues that we need to consider?

No

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

An audit was performed seven years ago but it was not very meaningful. The auditors did not seem to understand the accounting system, especially how the sub-accounts were to be maintained. It seemed to be a process that was new to the auditors.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

Yes, they use the OSHPD Internet site and had previously used the hard copy facsimile disclosure reports.

They utilize this information to study other hospitals' utilization patterns, and for making charity and disproportionate share comparisons. The information has also been used at times to analyze staffing and volume levels at other hospitals, but not on a routine basis.

Are you concerned that your hospital's data is available to others?

No

Do you have an estimate of time and resources that it takes to provide the data to OSHPD?

Quarterly Report:

Most of the data is already maintained by the hospital regardless of reporting requirements. The additional time for the actual reporting process is spent organizing and analyzing data, preparing the report and responding to OSHPD follow-up calls.

Four to eight hours are spent per quarter.

Calendar Year Utilization Report:

Again, most of the data is already maintained by the hospital. However it takes 20 to 40 hours to convert the information from a calendar year to a fiscal year basis.

Annual Disclosure Report:

It takes over 100 hours to maintain and organize the specific data that is reported, to prepare the actual report, and to answer OSHPD follow-up questions.

Most difficult worksheets to prepare include:

Pages 21 and 22 (Labor Distribution) – There is an accuracy issue over salaries/hours being reported on a functional basis. If nurses spend time providing services in non-nursing settings, these worksheets do not allow for proper reporting to occur. Also, the contract labor worksheets (pages 21a and 22a) are difficult to prepare because the hospital must obtain the necessary information from outside sources.

Do you have an estimate of the time and resources to provide the data for reporting to other state agencies?

They will contact us later to complete this section.

SALINAS VALLEY MEMORIAL HOSPITAL

Contacts: Mike Hutchinson
Vice President, Administration

Mike Lee
Assistant Controller

Specific Issues

Annual Utilization Report:

They would like to see the OSHPD Annual Utilization Report discontinued and any of relevant data added to the OSHPD Annual Disclosure Report. The combined report should be based on the hospital's fiscal year end.

Capitation:

It is appropriate to continue with the current reporting requirements for "out-of-plan" payments to other hospitals, by treating them as expenses to the responsible hospital.

They believe OSHPD should inform the data user on how to calculate area-wide or statewide information to avoid "double counting" situations, by explaining how total expenses can be reduced by purchased inpatient or outpatient managed care services. However, to accomplish this, OSHPD would need to separate purchased inpatient/outpatient services by those related to managed care and those related to other types of arrangements.

Charity/Bad Debt:

The difference between providing charity care and incurring bad debt is artificial. It is still free care. As long as the care is provided free, what difference does the definition make? However, if charity and bad debt continue to be differentiated, there should be some standard guidelines to follow for consistency.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

They would like to see the OSHPD Annual Disclosure report merged with the Medi-Cal Cost Report. They favor a reduction in the level of detail currently required by the OSHPD disclosure report. Consolidating the OSHPD report into the Medi-Cal report would be the best way to accomplish this objective.

Responsibility Accounting/Functional Accounting:

Uniform accounting requirements have not kept pace with changes in hospital operational practices. As a result hospitals have had to modify the uniform accounting system to capture the information necessary to meet operational needs. One example of this is outlined in the issue paper regarding the accounting and reporting of alternative birthing centers.

It would not jeopardize data accuracy to allow hospitals to maintain accounting systems that meet their operational needs. Uniform guidelines for reclassifications and estimates could still be provided to achieve a uniform functional reporting system.

Standard Units of Measure:

They support the concept of simplifying statistics. Currently the statistics are subject to various interpretations, which result in a lack of uniform reporting.

State Controller's Report/OSHPD Disclosure Report Consolidation:

They would like the State Controller's Report combined with the OSHPD Disclosure Report.

Are any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

Emergency Services Medical Authority Report

Annual Report to the Department of Corporations for those entities with a Knox-Keene license. It is filed monthly, quarterly and annually and includes:

- Basic financial data
- Enrollment data
- Insurance coverage
- Reserves

(Neither of these two reports could be replaced with information reported to OSHPD.)

Two other reports that they would like to see combined at the national level are the AHA annual survey and the joint commission report, which contain similar financial and utilization data. Although these are at outside of its jurisdiction, OSHPD may want to contact both entities and let them know that California hospitals would like to see a possible consolidation of reports.

Are there other issues that we need to consider?

They would like to see OSHPD explore the Colorado reporting model (of "macro level" data). They would not necessarily be adverse to a monthly reporting system in lieu of the three OSHPD reports currently required. Perhaps more current data at a "macro level" would provide more useful and more accurate information.

The quarterly reporting software is outdated. The current DOS program needs to be Windows-based. It also does not work with a lap top computer. A new program should be developed instead of simply updating the old program.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Yes, the Medi-Cal auditor did not seem to ask any substantive questions during the OSHPD portion of the audit, nor provide any useful insights. The auditor mostly performed a technical review of data that was part of their audit program.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

Yes, OSHPD statistics are used for benchmarking. However, they then contact hospitals selected for peer group comparisons to reconcile definition differences. This is especially true with respect to reported statistics.

They use OSHPD patient discharge information for DRG comparisons.

They would use the OSHPD data more if it were truly uniform. They are often forced to use Medicare and Medi-Cal information, and to contract with outside companies, to meet their data research needs.

Are you concerned that your hospital's data is available to others?

Yes, they do not like the fact that their competitors can identify specific hospitals. Although the information is not confidential, it can be sensitive.

Do you have an estimate of the time and resources to provide the data to OSHPD?

Quarterly Report:

Two hours per quarter is spent preparing the report. The information would be maintained regardless of reporting requirements.

Calendar Year Utilization Report:

Two days are spent preparing the report. Each department collects its own data, but it requires about a quarter FTE to gather and summarize all the information.

Annual Disclosure Report:

Approximately two weeks of preparation time.

Do you have an estimate of the time and resources to provide data for reporting to other state agencies?

It takes approximately three to four weeks to prepare the Medicare and Medi-Cal Cost Reports.

They would like to see the Medi-Cal Supplemental Worksheets eliminated.

Medi-Cal Cost Report: The report is prepared by a consultant and takes approximately three to four days to gather the data.

TENET HEALTHCARE CORPORATION

Contacts: Lily Runke
Manager

Mike Healy
Manager, Government Programs

Pat Strong
Government Report Preparer

Robert Flores
Government Report Preparer

Specific Issues

Annual Utilization Report:

The Annual Utilization Report is prepared by the individual hospitals. The Tenet System is not involved in the preparation of the report, and thus has no specific comments.

Capitation:

They would like to continue the current reporting method of expensing out-of-plan services and matching revenue with expenses.

They would like to see data users educated on the interpretation of information.

Charity/Bad Debt:

They believe there should not be a distinction between bad debt and charity care—but not differentiating would be impractical. Therefore, they recommend leaving the current OSHPD requirements as they are, allowing for individual hospital flexibility. Doing otherwise would create too many problems of appropriate

definitions and appropriate levels of enforcement. Hospitals, as well as their communities, may have differing needs for those who should be entitled to free care.

They would support an uncompensated care pool if additional funds, beyond those contributed by hospitals, were added to the health care system.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

They spend more time preparing the Medicare Cost Report than other hospital data reports. However, the Medi-Cal supplemental worksheets have become increasingly complex due to the additional detail and data continually added to the report.

They would like to see the Medi-Cal Cost Report and the OSHPD Disclosure Report consolidated, but at a more "macro" level—merging the two reports into the Medi-Cal cost report. They question data users' needs for the level of detail in the OSHPD Disclosure Report.

They do not recommend including the Medicare Cost Report in any consolidation. Such an effort may actually increase a hospital's workload.

Responsibility Accounting/Functional Accounting:

The current uniform functional accounting system is not necessarily meeting all of the hospital's operational needs. They do support uniform reporting, but believe improvements are needed. These improvements can be obtained by addressing non-uniform estimating or reclassification techniques.

The more detailed the data the less likely the information will be uniform. Data users need to be more realistic in terms of expectations.

Standard Units of Measure:

They support simplifying the statistics because of varying definitions or interpretations. This would not lessen the quality of the data any more than the current reporting requirements.

The reporting of RVS units is one specific problem area. The accumulation of this statistic even varies among the Tenet Hospitals.

They would not support the use of standard units of measure to achieve a total routine or ambulatory cost per unit. Maintaining the standard units of measure by routine and ancillary services may be difficult to accomplish accurately. If this information is necessary, the level of ancillary services in each routine or ambulatory department can be estimated by applying the Medicare and Medi-Cal

relationship to all payers. Medicare and Medi-Cal will represent the majority of the payer mix for most hospitals.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable.

Are there any reports submitted by the hospital other than the OSHPD, Medi-Cal and Controller's Reports?

None.

Are there other issues that we need to consider?

No.

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Their OSHPD Disclosure Report was audited, and they thought the experience was not very worthwhile. The auditor just went through the motions of following the audit program, and did not provide any analytical or insightful information. One member of the Tenet group, a former auditor with Medi-Cal, said Medi-Cal auditors operate under a 60-hour budget for the OSHPD review—and that time is being reduced. That person indicated the Medi-Cal office responsible for the review treated the OSHPD portion as more of a nuisance than a worthwhile pursuit.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

They are not sure if the departments in the Tenet Healthcare System use information about other hospitals obtained from OSHPD or other state agencies. The departments are more likely to use Medicare information.

Are you concerned that your hospital's data is available to others?

No

Do you have an estimate of the time and resources to provide the data to OSHPD?

Quarterly Report: It takes approximately two days per quarter per hospital.

Calendar Year Utilization Report: Not applicable.

Annual Disclosure Report: It takes approximately 200 hours per hospital for all phases of the report.

The most burdensome parts of the report have to do with providing ancillary statistics and completing the cash flow statement and statement of changes in equity. It would be preferable to eliminate these two statements from the disclosure report, and replace them with the requirement to submit the hospital's actual audited financial statements.

Do you have an estimate of the time and resources to provide reporting data for other state agencies?

Medicare and Medi-Cal Cost Reports: It takes a total of five months to prepare all of the reports for Tenet's 80 hospitals. For the 29 Medi-Cal Reports it takes approximately two weeks, using four FTE's, or about 10 hours per hospital.

UC SAN DIEGO

Contact: John Rogers
Director of Reimbursement

Specific Issues

Annual Utilization Report:

The Administrative Service Department completes the Annual Utilization Report. This department also deals with licensing, OSHPD, and other facility related matters.

Rogers finds certain sections of the report redundant. An example is inpatient utilization statistics. The financial disclosure report provides the same basic information on a fiscal year basis. Although there is other information on the annual utilization report (various statistics), most of it is not useful.

The most significant problem results from having to recalibrate fiscal year data to accommodate the calendar year reporting required on the annual utilization report.

Capitation:

Accounting for capitation payments is an important issue to the hospital. The issue relates to the hospital that collects the premium and is responsible for providing services to a patient. There is not an issue when the same hospital collecting the premium actually provides the service. The problem arises when the hospital that receives the premium cannot provide the service and must transfer the patient to another hospital for care. When UC transfers the patient it records the line item expense, but does not record the days or revenue. The hospital then sets up internal reserves to cover out-of-service expenses that may exceed the premiums being collected. This is consistent with the OSHPD requirements.

The question is whether the draw down against the capitation dollars should be recorded under contractual allowances or as an offset against the capitation revenue, instead of expenses. Although there seems to be rationale for tying

them to premiums, especially when there are no associated days or revenue, there is also a rationale for recording them as expenses since the hospital is "at risk" for providing the services. If they are not recorded as expenses, there could also be implications for the hospital's disproportionate share payments that need to be taken into consideration.

Because the capitation revenue is now recorded by payer category, the expense reported as "purchased inpatient or outpatient services" should be reported by the same payer categories. However, this may be difficult to capture on the hospital's current books and records.

He favors the status quo, as a practical matter. This will not affect disproportionate share payments, and is consistent with how they currently maintain their records.

Charity/Bad Debt:

This hospital has a charity policy that is payer-driven. Two types of patients use the charity program:

- Those who have no health insurance and do not pay.
- The indigent patient not covered by any government programs.

He is not sure whether a standardized definition should be applied. He questions if it would be practical and objective, and would need to know the specifics before making a judgment. Even if it does make sense, could it be implemented on a practical basis?

The workload to document charity care is already extensive. He is concerned that a more definitive requirement might further increase the workload. He would not support a change in definition that increased required documentation or added to the existing government audits.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

UC San Diego is a contract hospital for Medi-Cal, so the OSHPD report is more important. Although the Medi-Cal cost report is not used, they don't want a consolidated report that shifts the workload of Medi-Cal auditors to an audit of the consolidated report.

The current Medi-Cal audit focuses on billing and credit balance issues. It is not a problem, and usually takes less than two weeks per year.

He agrees with the goal of eliminating redundancies and supports the concept of a consolidated report. However, he is just as concerned that the savings achieved through a consolidated report could be lost through increased audits.

He would prefer to see the Medi-Cal cost report combined with the OSHPD report in any consolidation. He believes this consolidated OSHPD report could be used as both a reimbursement tool and to provide comparative data for health care policy needs.

Responsibility Accounting/Functional Accounting:

He thinks more flexibility should be allowed in the current uniform accounting system. Perhaps the level of detail within an accounting system should be left to the discretion of the hospital, such as within the sub-accounts or the use of statistics. The value of the information should be considered when determining how strict or uniform the rules should be.

Standard Units of Measure:

Inpatient days and outpatient visits are not a problem.

Ambulatory statistics by payer are a problem since because usually do not follow the revenue payer reclassifications.

Ancillary services statistics –- Cesarean section should be included in labor and delivery, not operating room. Units of blood are a problem due to varying interpretations. Cardiac catheterization procedures are a problem because different labs have varying levels of sophistication. RVS units are not always current and can be very time consuming to collect. MRI minutes are difficult to determine because that is not the method for charging for this service. Respiratory therapy treatments are difficult to measure. The definition is difficult to interpret and it is confusing.

Support service statistics – these statistics are not very comparable between hospitals and are not usually used as benchmarking measures.

Other statistics – units of measure such as referred ancillary services are not used to compare costs per unit and are not comparable between hospitals. Renal dialysis should only capture the number of treatments, not hours.

In summary, a measure such as an adjusted inpatient day (*e.g.,* medical supplies and drugs) may be more beneficial. They are not only likely to be more comparable and less burdensome, but are more relevant because they are tied to a patient base.

State Controller's Report/OSHPD Disclosure Report Consolidation:

Not applicable

Are there any other reports submitted by the hospital, other than the OSHPD, Medi-Cal and Controller's Reports that we have identified:

None

Are there other issues that we need to consider?

No

Has your hospital ever had its OSHPD disclosure report audited by Medi-Cal?

Rogers had an audit about 10 years ago; another will be performed this year. This is his recollection of the earlier experience:

- It was a mechanical exercise.
- The auditor did not understand what was being looking at or what the audit program was supposed to accomplish.
- The hospital was sent a threatening letter explaining it was out of compliance. This was not true; rather, the auditor did not understand the accounting system.
- Overall, it was not a very productive process.

Do you ever obtain information about other hospitals from OSHPD or other state agencies?

He utilizes the hard copy of the OSHPD disclosure reports, and prefers that to a diskette or electronic copy. It is difficult to extract information from the electronic report, which is also incomplete. He believes there should be a requirement that OSHPD provide data users with a hard copy upon request. (Note: We learned upon follow-up with OSHPD staff that the hospital was given incorrect information, and that the hard copy facsimile of the annual disclosure report is still available upon request.)

The hospital uses the hard copy of the annual disclosure report for benchmarking costs and services provided by other hospitals, and to compare payment levels for different programs with those at other hospitals–in particular, payments under the disproportionate share program. They also utilize the OSHPD quarterly reports for analyzing more "macro" level market share information. They also use the OSHPD discharge data reports.

Are you concerned that your hospital's data is available to others?

One problem is press misunderstanding of the hospital's true financial situation as a result of the misreporting of disproportionate share payments. Otherwise, they have no problem with others looking at the data reported to OSHPD.

Do you have an estimate of time and resources that it takes to provide the data to OSHPD?

Quarterly Report: A couple of days per quarter are needed for the actual preparation of the reports. It also takes a couple of days per quarter to maintain the data, beyond the information the hospital would have maintained for its own internal uses anyway.

Calendar Year Utilization Report: A few weeks are needed–one week to prepare, and one to two weeks to maintain and gather information.

Annual Disclosure Report: One month of preparation, including gathering all information. One month of maintaining the required information throughout all of the departments.

Most difficult report pages to complete, and likely the least accurate include:

Standard Units of Measure

Allocation Statistics

Labor Distribution, including contract services

Financial Statements – difficult to transfer audited financial statement data to OSHPD worksheets. Also, he is not sure of the purpose of long-term debt worksheet, and would like to see it eliminated.

Do you have an estimate of time and resources that it takes to provide the data for reporting to other state agencies?

One week for the Medicare cost report and one week for the Medi-Cal cost report to gather the necessary data and complete the reports, beyond the data already being collected for management purposes. The entire preparation time, however, is over a two-month period, including using data the hospital already maintains.

CALIFORNIA HEALTHCARE ASSOCIATION / REGIONAL HOSPITAL ASSOCIATIONS / CONSTITUENCY GROUPS

Attendees: Sharon Avery, California Healthcare Association
Jay Benson, OSHPD
Glory Ann Bryant, Tenet Health Systems
Michael Dimmitt, California Healthcare Association
Jim Foley, Managed Care Support Systems
Barbara Glaser, Association of California Hospital Districts
Barbara Jones, California Healthcare Association
Kenny Kwong, OSHPD
Heather Lester, CCHA
John Mosher, Kaiser Permanente-Northern Region
Santiago Munoz, California Association of Public Hospitals
Allan Redmond, Kaiser Permanente-Northern Region
John Turek, University of California
Shelly Schlenker, Hospital Council

Note: this was a meeting of the above individuals rather than an individual interview.

Specific Issues

Annual Utilization Report:

No Comments.

Capitation:

Regarding the OSHPD requirements related to capitation accounting there was concern that the current accounting and reporting requirements have limited the data user's ability to compare hospital revenues and expenses as more and more patients are treated under capitation agreements. Hospitals have been recording capitation premiums and related expenses related to out-of-plan services in an inconsistent manner. It was suggested that a better method would be to divide the capitation premiums in a manner that separates patient revenue between the hospital providing patient care and the hospital responsible for the patient's care that is acting, in essence as an insurance entity. If those two can be divided it would provide a clearer picture for making comparative analyses. It was noted that some accounting issues being further explored with OSHPD are how to account for situations where hospitals take their capitation premium and sub-contract out the services on a capitation basis or on a per diem basis to other facilities.

Charity/Bad Debt:

This issue involved a lengthy discussion. There was a strong feeling from the data users' prospective that charity must be reported accurately for use in decisions effecting the hospitals public perception and tax-exempt status. There was also the opinion that hospitals do not believe the benefit of documenting that a patient is eligible for charity is worth the cost of resources needed to obtain such documentation.

Those who are in favor of a standardized definition of charity see a need for consistency in reporting definitions. If charity reporting is accurate and uniform it will be used more. Accurate and uniform data is needed to evaluate and compare patient care and community benefits of hospitals. This would help to alleviate some of the scrutiny by consumer groups regarding care being given to the poor. Currently, consumer groups can use their own definition of charity care in order to put pressure on hospitals to provide a certain level of service. Another concern dealt with the idea of a non-profit hospital switching to a for-profit status due to a change in its charity/bad debt definition.

The opposing view believed that a standard definition of charity was not really the issue. They believed that more accurate data could be achieved if hospitals placed more effort in determining the true financial status of patients. Many more patients would also be eligible for charity care if a better method of qualifying patients were in place. They believe an effort to move hospitals in the direction of qualifying patients would be more suitable than enforcing a standard definition of charity.

There was a concern that quarterly reporting of bad debt/charity is inaccurate because of the time lag involved. The quarterly report is a snapshot of time in which information is still being gathered before it is determined as to whether or not the patient meets the charity guidelines or if they meet Medi-Cal eligibility.

One member indicated that he believes the discussion of standardizing the charity definition is beyond the scope of this reporting project. He believes the definition of charity is a policy issue, not reporting issue.

Medi-Cal Cost Report/OSHPD Disclosure Report Consolidation:

There was not a strong position regarding the consolidation of the Medi-Cal cost report and OSHPD disclosure report. However, a point was made that if consolidation were to happen, the OSHPD Disclosure report should be the surviving report. It has traditionally been very difficult to obtain data from the Department of Health Services. The data is simply not available until the completion of the prolonged audit process. There are many barriers that make consolidation to the Medi-Cal side less attractive than consolidating to the OSHPD side.

If the two reports were to be consolidated, with OSHPD as the surviving report, the OSHPD system would have to produce the Medi-Cal reimbursement related pages for DHS. This may help eliminate the problem of not having data available due to a prolonged audit process. However, the group did raise the concern that there should not be two different agencies auditing the same report. Otherwise, it would eliminate any efficiencies that were gained through consolidation.

Responsibility Accounting/Functional Accounting:

No comments

Standard Units of Measure:

No comments

State Controller's Report/OSHPD Disclosure Report Consolidation:

No comments

Part 4
Interviews with State Agencies

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BACKGROUND AND SUMMARY

The previous part focused on those required to collect and file data with state agencies. This part is devoted to perceptions of the state agencies that receive and publish the data. The specific agencies were selected based upon information known to the project members, recommendations of other state agencies, and suggestions from OSHPD staff.

The agencies were primarily in the Department of Health Services and OSHPD. They are:

Department of Health Services:

- Audits and Investigations Audit Review and Analysis Section
- Disproportionate Share Hospital Program Unit
- Health Information and Strategic Planning Division
- Licensing and Certification Division

OSHPD:

- Accounting and Reporting Systems Section
- Cal-Mortgage Loan Insurance Division
- Healthcare Information Resource Center
- Hospital Community Benefit Program
- Licensed Services Data and Compliance Unit

Other:

- California Medical Assistance Commission
- California State Auditor
- Department of Mental Health
- Emergency Medical Services Authority

- State Controller's Office

The interviews addressed the activities of the agencies in collecting data from hospitals. In addition, the agencies were asked questions to obtain their views as data users, if applicable.

These interviews are described on the following pages.

DEPARTMENT OF HEALTH SERVICES

Audits and Investigations
Audit Review and Analysis Section

Contact: Frank G. Vanacore, Chief
Gary Wong, Supervisor

The Audit Review and Analysis Section is responsible for the collection, editing and auditing process associated with hospital submission of the Medi-Cal cost report (HCFA Form 2552-96) and related supplemental worksheets. These include the Audits and Investigations (A&I) supplemental worksheets, Rate Development Branch (RDB) worksheets and County Medical Services Program (CMSP) worksheets.

The Medi-Cal cost report and related supplemental worksheets must be submitted to Audits and Investigations no later than 150 days after a hospital's fiscal year. There are no extensions allowed. There are, however, various exceptions and modifications permitted that recognize changes in ownership, low Medi-Cal utilization and extraordinary events. These are described in detail in an earlier chapter on exceptions, exemptions and modifications.

The cost report is used to determine Medi-Cal inpatient and rural health clinic cost settlements and to set Medi-Cal rates for hospital-based skilled nursing facilities. The Audits and Investigations unit does not use data collected by other state agencies for this purpose. The data contained in the cost report are not published or distributed to data users. The only publication of data is a final audit report provided to each hospital. Through the Public Records Act a data user can obtain the cost report and any related work papers.

Audits and Investigations does not review the HCFA Form 2552-96 to determine if modifications should be made to meet the needs of the Medi-Cal program. If additional data were needed for Medi-Cal cost settlement purposes or rate setting purposes, more data fields would be added to the Medi-Cal supplemental forms. The Medi-Cal supplemental forms are reviewed as needed. Al-

though there is no on-going schedule for review, the forms have been evaluated annually over the last few years. Data elements have been deleted (recently two hospital-based skilled nursing worksheets) and added (data related to hospital-based physicians that Medicare eliminated from the HCFA Form 2552-96).

Although Audits and Investigations does not outright oppose exploring the consolidation of the Medi-Cal cost report with the OSHPD annual disclosure report, they have many concerns and questions that need to be addressed. These include the following:

- Will there be a benefit to hospitals if the consolidation does not include the current Medicare cost report? In fact, could the hospital workload actually increase if the Medicare cost report is filed along with a consolidated Medi-Cal cost report/OSHPD disclosure report? The current Medi-Cal cost report does not require much effort to complete once a Medicare cost report is prepared. Perhaps California should seek a waiver from HCFA for a demonstration project that could permit a consolidated report to HCFA in lieu of the current Medicare cost report.
- Could a consolidated report provide the supplemental information needed to determine appropriate payment levels for hospital-based rural health clinics, FQHCs and skilled nursing units?
- Could the needs of public disclosure be met without jeopardizing any confidential reimbursement data?
- Are the time constraints for Medi-Cal rate setting and cost reimbursement compromised by the editing and publishing of a consolidated report? Priorities may need to be established for the edit and review of consolidated reports that have rate setting implications.
- Would hospitals that need not file a Medi-Cal cost report (low utilization providers) be required to file a consolidated report?
- Can the technology capabilities of Audits and Investigations and OHSPD be tailored to accept electronic submissions of data and electronic transfers of information?
- Can the modifications and exceptions of both programs be reconciled? For example, would a low Medi-Cal utilization hospital that is exempt from filing a Medi-Cal cost report be required to file the consolidated report?

To better respond to the consolidated report concept, Audits and Investigations would need to evaluate a "draft" working document that provided specific schedules and addressed concerns similar to those outlined above. Other issues

that would also have to be explored include the procedures for editing and auditing the data, for amending the report and for appealing audit findings.

Disproportionate Share Hospital Program Unit

Contacts: Carolynn Michaels
Chief

Marcella Enos
Health Program Auditor III

Michael Fitzwater
Research Analyst II

Lynne Herren
Research Analyst II

The Disproportionate Share Hospital (DSH) Unit is primarily a user of data, but also performs surveys to collect hospital information. This data collection effort is targeted at a select group of hospitals with very rapid turnaround required to complete the disproportionate share calculations described below. The data are collected from a relatively small number of hospitals and limited to only a few elements. The information must be available within less than 30 days and consists of projections of future revenue and expense. As a result, the data collection does not lend itself to inclusion with other state required reporting and no recommendations about it will be made in this report.

However, as data users, the DSU Unit has its own recommendations and comments concerning hospital reporting to OSHPD. These are:

- Short-Doyle/Medi-Cal Mental Health revenues should be identified separately from other third party revenues.
- When fully implemented, the identification of managed care revenues by payer on the Hospital Annual Disclosure Report will be of benefit to the unit.
- For OSHPD report periods ending on or after June 30, 2000, OSHPD should include enough detail on the new page 4.1(1) to allow the unit to identify the equivalent data found on page 4(1) lines 75 and 100-145.

The DSH Unit administers the Medi-Cal disproportionate share hospital program. Under this program, hospitals that provide services to a disproportionate share of Medicaid and other low-income patients receive supplemental payment adjustments over and above other Medi-Cal payments. The program is often

identified by the legislation that established it, Senate Bill 855 (Chapter 279, Statutes of 1991). The unit determines the hospitals eligible for disproportionate share payments, the amount of those payments and the calculation of limits on the payments. In addition, the unit calculates the intergovernmental transfers (for the non-federal portion of the funding) of the affiliated public entities.

The unit uses the OSHPD Hospital Annual Disclosure Report extensively. The statute requires this report be used and specifies the date when the data are to be provided by OSHPD. The information used comes from pages 0, 4.1 (pages 4(1) and 4.1(1) for OSHPD report periods ending on or after June 30, 2000), 8 and 12 of the report and includes specific utilization, revenue and expense information. Because the data used are not for the most recent period, the length of time for hospitals to report to OSHPD and for OSHPD to release the data is not an issue. For example, the DSH eligibility and payment information for the state fiscal year that began July 1, 1999, is based upon annual reports for fiscal years ending in calendar year 1997.

The unit must supplement the OSHPD Hospital Annual Disclosure Reports with other data. This includes information from both Licensing and Certification and OSHPD on the status of hospital licensure. Medi-Cal paid claims information is used to determine the number of Medi-Cal patient days as well as revenue generated from Short-Doyle/Medi-Cal patients. (The Short-Doyle/Medi-Cal program is described in more detail in the description of the interview with the Department of Mental Health.) The separate reporting of Short-Doyle/Medi-Cal revenue on page 12 of the annual OSHPD report would be a more reliable source of information than the Medi-Cal paid claims, according to DSH Unit staff. At a minimum, they would like Short-Doyle/Medi-Cal net revenue to be reported.

Medi-Cal managed care information comes from two sources. For eligibility purposes, discharge data report information is obtained from OSHPD and compared to Medi-Cal eligibility files to identify services provided to Medi-Cal beneficiaries in managed care plans. Secondly, Medi-Cal managed care plans are requested by the unit to report on the number of covered inpatient days and revenues. This is used to determine payment amounts. The managed care revenue data to be available from the revised OSHPD report will be used to calculate the low-income percent and the uncompensated costs (or OBRA limits). However, the DSH Unit will still obtain Medi-Cal managed days from OSHPD's discharge file for Medicaid utilization rates and will continue to survey the managed care plans for revenues and days used in the payment calculations.

Besides the use of the data from other sources, the DSH Unit must also obtain information directly from certain hospitals. Once the initial list of eligible hos-

pitals is developed and the projected allowable payments calculated, the eligible hospitals are surveyed for certain revenues and expenses not otherwise available. These revenues and expenses are used in the formula that projects the hospital's "OBRA 1993 limits"–imposed by the federal government to ensure hospitals do not receive DSH funds in excess of their "current" uncompensated costs for services to Medi-Cal and low-income patients.

Only about one quarter of eligible hospitals are affected by the two surveys. The first gathers the amount of funds the hospitals have received or expect to receive under the Medi-Cal Construction, Renovation and Replacement Program (SB 1732). The second, which involves an even smaller group of county-only hospitals, obtains projections of Medi-Cal Administrative Activities expenses and Targeted Case Management revenues. Because only a small group of hospitals actually participate in this process and, more importantly, because the surveys involve projections as well as historical data, they are not suitable for incorporation with other hospital state agency reports. Both surveys are brief and, because the final DSH payment calculations cannot take place without these data, the participating hospitals usually only have a short period in which to respond. It is important to note that the DSH Unit has no authority to validate any of the reported data, and makes no attempt to do so.

The issue of whether and how public hospitals do (or could) report transfers between the public DSH hospitals and their associated public entities was discussed. The unit has no jurisdiction over DSH funds once they are paid to the appropriate hospitals. Moreover, the specific data is to be included in the hospitals' OSHPD reports is determined by OSHPD, not their Department.

Health Information and Strategic Planning division

Contact: George B. (Peter) Abbott, M.D., M.P.H.
Acting Deputy Director)

The Health Information and Strategic Planning Division of the Department of Health Services (DHS) is comprised of two branches. They are the Center for Health Statistics, Planning and Data Analysis Section, and the Office of County Health Services (OCHS).

Dr. Abbott explained that the Center for Health Statistics does not collect hospital financial/utilization relevant to this project. All their data analysis uses OSHPD hospital discharge information.

The Office of County Health Services, however, collects health care related information to determine how each county is meeting its legal obligation to provide health care to indigents who lack public or private financial support. All data collected specifically relate to indigent patients. The data are used to help local and state officials assess indigent patients' health care issues.

OCHS collects health care information from three separate reports. Copies of these reports and related instructions appear in the Appendix. Two of these reports are completed not at the hospital but at the county level. They include information on all health care services provided to indigent patients, whether in hospital settings or in outpatient clinics. The two reports are the Medically Indigent Care Reporting System (MICRS) and the Trust/Special Revenue Fund Balance Report.

The MICRS report provides data on expenditures for health care to indigents. It includes all indigent expenditures paid for in whole or in part by Realignment funds, Rural Health Services funds, California Health Care for Indigent Program funds, or any other funding to meet the county's Section 17000 obligations. There are 24 counties that accept funding under the California Healthcare for Indigents Program (CHIP), while three counties receive funds from the Rural Health Services Program. All 58 counties collect data from health care providers to complete the MICRS, but no uniform reports are sent to hospitals or other providers for completion.

Counties that accept tobacco tax funding complete the Trust/Special Revenue Fund Balance Report, which shows how the funds are spent–including expenditures at the hospital level.

We do not believe that the data in either the MICRS or the Trust/Special Revenue Fund Balance Report could be collected directly at the state level by any agency now collecting hospital-specific data. The focus of these reports is on care provided to indigent patients and includes more than hospital information.

The third report is completed at the hospital level and sent directly to County Health Services. This report is required for the Hospital Services Contract Back (HSCB) Program, for hospitals that wish to participate in the tobacco tax distribution program but whose counties have chosen not to participate. The report is completed quarterly and is used to determine hospital payment levels under the tobacco tax-funding program. It collects data on patients who qualify for the program and who do not pay for the health care services they receive.

This report is limited to the charity care cases, usually representing a small portion of a hospital's total charity care. It is also limited to rural hospitals and is patient specific. Therefore, it does not appear that any of the current financial and utilization reports submitted to the Health Information and Strategic Planning Division should be included in the recommendations of this study.

Licensing and Certification Division

Contacts: John Haggerty

Lori McLean

The Department of Health Services (DHS) Licensing & Certification (L&C) Division collects and maintains hospital data useful in the survey, licensing and certification process. Hospital specific data profiles are maintained by L&C. However, these profiles contain no financial or utilization elements but rather such facility descriptive data as type of facility, permitted supplemental services, complaints, survey findings and actions taken by L&C.

The Department of Health Services has periodically published a statewide hospital directory listing hospitals by type and describing the supplemental services offered by each facility.

Although it is a minor area of duplication, both OSHPD and L&C maintain lists of services for each hospital in their respective data systems.

Some data collected by L&C are forwarded via modem to the Health Care Financing Administration (HCFA) for federal certification purposes. HCFA and L&C are working toward development of a new data system with a closer linkage between the two. The new data system is expected to provide direct online usage by L&C, improve access to hospital specific data, enhance efficiency (by such means as avoiding re-keying of data), and facilitate more timely availability of hospital specific data. Timelines for development of the new system were not available.

The DHS Licensing & Certification Division is a frequent user of the OSHPD database, for a variety of purposes. These include: evaluating performance by specific hospitals, developing trend data for particular geographic regions or types of hospital service, evaluating needs for modified regulations or new legislation, and developing responses to administrative or legislative requests.

Trend studies are the most frequent use of OSHPD data by L&C. For example, the division may evaluate a specific hospital's permit to determine if the hospital is meeting the requirements for licensing. Two typical hospital services evaluated with assistance from the OSHPD database are cardiovascular surgery and neonatal intensive care. Licensing & Certification may establish utilization trends to evaluate performance by a specific licensee. Evaluations could include factors such as volume of cases, diagnoses, outcomes and financial perform-

ance factors. Although the primary focus is on clinical factors, financial data are useful in understanding the overall performance of a particular hospital. A hospital struggling financially may be less able to consistently maintain high quality, particularly if the program in question is a high cost service line. Financial problems may also be an indicator of whether a hospital will continue to comply with all aspects of regulation.

Licensing & Certification staff expressed more concern about the timeliness of financial data than the timeliness of utilization data. This was attributed to their use of utilization data for trending purposes. However, a hospital's financial problems will not be identifiable through trend analysis until it is too late to be useful for Licensing & Certification enforcement purposes.

Licensing & Certification staff are frequently interested in custom reports, which address a particular area of interest under study by the department. Although access to OSHPD data was not considered a problem, L&C staff felt that access could be enhanced. They suggested that OSHPD could:

- develop a user dictionary which describes all the data elements, how they are collected and how they are reported; and
- provide an interdepartmental contact who can work with L&C to formulate custom report run requests or creation of data files which can then be analyzed by L&C staff.

The DHS Licensing & Certification staff expressed concern about enforcing regulations on OSHPD reporting. L&C perceive that they have the enforcement responsibility for OSHPD, a view that stems from requests to not relicense hospitals out of compliance with OSHPD reporting requirements. L&C staff say DHS has never taken a license from a health care provider for not complying with OSHPD's reporting regulations. Although OSHPD already has enforcement authority and specific sanctions in place, the Licensing & Certification Division recommended that enforcement authority be specifically assigned to OSHPD, even if legislation is necessary.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Accounting and Reporting Systems Section

Contact: Kenrick J. Kwong, Health Program Audit Manager I

Hospital Financial Data Unit

The OSHPD Accounting and Reporting Systems Section's Hospital Financial Data Unit is responsible for maintaining the OSHPD uniform accounting and reporting system required of all California hospitals. This includes the required quarterly and annual financial and utilization reporting. Specifically, their functions can be defined as systems development, technical review, and analytical review.

The systems development responsibilities involve the implementation of regulatory changes; and administrative hospital manual changes; and the development and maintenance of computer systems to add, edit, and disclose submitted data. One full-time equivalent employee, with supervision and input from Mr. Kwong, staffs this function.

The desk audit review process for annual disclosure reports is a two-stage process involving a technical and analytical review process. Staffing consists of five to six part-time employees for performing the technical review, with six full-time employees involved in the analytical review process. The audit staff work under the direction of a Lead Analyst.

Submitted annual disclosure reports are received electronically and added to a PC and mainframe database. A computer program performs numerous edits against the mainframe database and produces an edit report for the desk audit review process. Submitted quarterly reports are received electronically and added to a PC database, where edit checks are performed for the desk review process.

The desk audit review process is performed using PC-based applications to submit corrections to the PC and mainframe databases. Edits are applied on the mainframe system for the annual report, and only made on the PC system for the quarterly report. The desk audit includes analysis, identification, correction and documentation of accounting and reporting errors. The desk audit is a two-stage process for the annual disclosure report, and a one-step process for the quarterly report.

The first step in the annual disclosure report process involves a technical review of approximately 2.5 hours per report. Simple reporting errors are corrected, while more complex errors are identified for the analytical review process. Included in this technical review is a comparison between key financial and utilization data items on both the annual and quarterly reports.

The second step is the analytical review that involves a more detailed review of the annual report. This part of the review process is estimated to take about 9.5 hours per annual report. It includes a review of the technician's corrections and notes, the development of a list of outstanding issues and the resolution of all remaining errors. The analyst works with the hospital report preparer to correct or document support for the list of outstanding issues. Each annual report involves an average of approximately 5.5 cycles of corrections before it is considered complete. Once the report is complete, the analyst finalizes the report by having the optional data fields processed (e.g. the cost allocation). The analyst then sends a letter to the hospital along with the finalized corrected annual report. Only about two percent of the annual reports have to be returned to the report preparer for corrections that cannot be made by FAX or telephone by the report analyst.

A final review is performed by the Unit's Lead Analyst to ensure that accounting and reporting issues were identified and resolved according to established desk auditing guidelines. The Lead Analyst may require the report analysts to contact the report preparer for additional corrections and/or explanations.

The desk review of the quarterly report only includes the analytical review process and takes approximately .75 hours per quarterly report. It is identical to the annual review process described above, but is less time consuming.

Hospitals are required to submit annual disclosure reports electronically using third-party vendor software approved by the Office. The approved software must contain Office-defined edits. The PC diskette edit specifications fall into four categories: 1) software-completed, 2) fatal edits, 3) warning edits, and 4) optional edits. The software-completed phase provides formulas for the completion of data fields where amounts should be automatically transferred. These include

column and line totals, formulas and statistics transferred from previously input data fields. The fatal edits must be resolved by the hospital report preparer and are comprised of data elements that prohibit the data file from being submitted. Warning edits indicate that potential reporting errors may exist. These are provided as part of the software package that allows the report preparer to verify the accuracy of specified reported data elements. Optional edits are not required for the software package, but if implemented would be treated the same as warning edits. It should be noted that if a hospital's report has data that appear extremely out-of-line with industry standards, and the hospital preparer insists upon its accuracy, than OSHPD will request the preparer to sign a data verification letter.

In the early 1980s, the Auditor General's Office issued a report that advised the Office to conduct limited field audits to ensure the accuracy of submitted data. Beginning in 1984 OSHPD established a random field auditing process through a contractual arrangement with the Medi-Cal Audit Review and Analysis Section of the Department of Health Services (DHS). Approximately 40 hospitals and 40 free standing long-term care facilities per year are audited at an annual cost of $250,000 to OSHPD. Ken G. Winn is the Facility Compliance Officer that coordinates the field audit function with DHS, and acts in the role of the OSHPD liaison. The following information was provided in a separate interview with Mr. Winn.

Until this year, likely through a misunderstanding, DHS only provided a list of hospitals with distinct part skilled nursing facilities as those available to OSHPD for this joint audit function. Therefore, the random auditing function was limited to these few facilities. In addition, if the hospitals did not have any Medi-Cal business they too would be excluded from this audit.

OSHPD provides DHS with a seven-page audit program to follow. Each item on the audit program identifies whether the hospital meets or does not meet the OSHPD requirements. The auditor is to provide comments on those items that do not meet the requirements and indicate whether or not the hospital agrees with their findings.

According to Mr. Winn, DHS spent 2000 hours in the previous year in performing the OSHPD portion of the joint audit, on both the hospital and long-term care facility reports. This included both the auditors' and supervisors' time, and included both the field and office work. If 86 audits were performed in the prior year (43 hospital and 43 long-term care) as indicated by Mr. Winn, the average time per audit would have been 23 hours. The average hourly rate paid by OSHPD to DHS for these audits would be $125 ($250,000 divided by 2000 hours).

Mr. Winn participates in as many joint Medi-Cal/OSHPD audit exit conferences as possible, which he estimates to be about 60% of total exit conferences. He believes that the Medi-Cal auditors are meeting the minimum requirements as specified by OSHPD, but is concerned about their level of interest and commitment to the OSHPD accounting and reporting requirements. The OSHPD audit is not a priority with DHS; therefore, if this function were a part of OSHPD's responsibilities, a more productive audit would possibly occur. Mr. Winn indicated that it is likely that OSHPD staff could be of more assistance to the hospitals as a result of their experience with the OSHPD report. Their objective is to provide guidance and not be in an adversarial role. In addition, the audit could be performed according to OSHPD's schedule and needs, and have to rely solely upon Medi-Cal's schedules and priorities. Lastly, an OSHPD-conducted field audit would provide invaluable experience, training, and knowledge to OSHPD's desk audit staff.

The interview was concluded with a brief discussion of what accounting or reporting changes Mr. Kwong would like to see considered. He indicated that he would like to see the quarterly financial and utilization reports expanded to provide some payroll and more detailed expense information if it could be readily reported by the hospitals.

A follow-up interview was conducted with Mr. Kwong and Mr. Jay Benson, Manager of the OSHPD Accounting and Reporting Systems Section, to discuss their views on the various issues raised during the individual hospital interviews. There responses regarding each issue are as follows:

Should the OSHPD Annual Utilization Report be combined with the OSHPD Annual Disclosure Report? Yes. The annual utilization report should be eliminated with the useful data elements retained on the annual disclosure report and reported on a hospital fiscal year basis. It should be noted that any change in report due date (currently the utilization report is due February 15th) and reported data elements would require a legislative change.

One issue that would have to be clarified for those currently utilizing the Annual Utilization report is the situation related to consolidated licenses. The Annual Utilization report requires two separate reports while the disclosure report requires one combined report.

Does the OSHPD accounting system appropriately capture the costs associated with out-of-plan capitation arrangements? Yes. It is appropriate to recognize the costs incurred by the hospital providing care to the beneficiary and the costs associated with the payment of those services by the hospital that is responsible for the care of the beneficiary when out-of-plan services occur.

The concern over the "double-counting" of expenses when there are costs reported by two hospitals related to the provision of the same service may not be a material problem and should be analyzed further before any changes are recommended.

If a hospital is acting as an insurance company where a significant portion of their capitated business relates to the provision of out-of-plan services, the costs, revenues and statistics for such services should not be included on the hospital's books. In those situations the capitated business should be treated as a separate entity. However, if the activity is part of a health system and cannot be separated, then the related costs and revenues should be treated as non-operating.

Should there be a standard definition for charity care? No. California is too diverse where one definition would not have universal application. Also, there is a question as to whether OSHPD has the necessary qualifications and expertise to develop and maintain a standard definition, or to evaluate and approve customized definitions. There was agreement that a differentiation between bad debt and charity care should be continued.

Two additions to the disclosure report should be continued as they relate to charity care and community benefit standards. These include:

- Provide for specific charity questions that can be included in the OSHPD database. For example, does the hospital have a specific written charity care policy? Is the policy based upon federal poverty guidelines? If so, at what level of the federal poverty guidelines?
- Set up specific community benefit questionnaire based upon the SB 697 Community Benefit Report filed by hospitals. Develop common questions from the narrative reports already filed by hospitals, and allow for "yes," "no," and dollar amount responses.

Should the Medi-Cal cost report and OSHPD disclosure report be combined? Yes. The reports should be combined utilizing the OSHPD report as the basis. This system works well for the long-term care consolidated reports.

OSHPD provides for better technology, is more data user oriented, and is capable of providing the Department of Health Services with the information it requires for its Medi-Cal program. They would only want to consider including the Medicare cost report as part of the consolidated report through a demonstration project if the Health Care Financing Administration would accept the consolidated report without significant changes so as not to impact OSHPD's disclosure report time frames.

How should OSHPD address problems related to compliance with the uniform functional accounting system? They recommend that OSHPD study how hospitals are organized from an accounting and operational standpoint. Changes may need to be made within the OSHPD accounting/reporting system to better accommodate hospital management needs and to better achieve uniform reporting.

Before assuming a need for developing more uniform estimating or reclassification techniques to achieve better uniform reporting, determine the specific problems, and evaluate why they are occurring.

How should OSHPD address problems related to the accounting and reporting of the uniform standard units of measure? They recommend that the statistics be evaluated on a case-by-case basis. Those that are burdensome to collect, as well as less likely to be reported in a uniform manner should be changed. The alternative statistics should still attempt to relate to the resource allocation of the department, as opposed to a patient day or revenue approach. For example, the statistic for laboratory was changed a few years ago from CAP workload units to tests. Therefore, if the use of RVS units for radiology were a problem, it would likely be better to change the statistic to exams, as opposed to an adjusted inpatient day. Although an adjusted inpatient day is simple to calculate, and would be uniform (which was the basis for using this statistic for supplies and drugs), it does not provide for a measure of resource allocation.

Should the State Controller's Report filed by district hospitals be consolidated with the OSHPD Annual Disclosure Report? Yes. Adding a few schedules to the current OSHPD disclosure report to collect the additional information for the State Controller's Office would not appear to increase the workload at OSHPD. Most of the information is already being collected on the OSHPD disclosure report.

Should OSHPD consider changes to the disclosure report field audit function? Yes. OSHPD should evaluate whether the current on-site audit function that is accomplished through a contractual arrangement with the Department of Health Services (DHS) is accomplishing its objectives. In addition, there could be advantages to performing the field audit function internally with OSHPD staff. For example, this activity could improve OSHPD staff expertise, and OSHPD and hospital relationships. Also, this activity could be used to evaluate and identify accounting and reporting issues at the hospital level.

Cal-Mortgage Loan Insurance Division

Contact: Dale A. Flournoy

Construction Financing Supervisor

Stephen A. Beckman, Jr.
Project Officer

The Cal-Mortgage Loan Insurance Division of OSHPD provides a loan insurance program for needed capital projects of non-profit health facilities. These projects include acquisitions, renovations, refinancing, and expansions that are financially feasible. The program is administered without risk to the state's general fund.

Cal-Mortgage seeks information and data directly from the health facility during the application process. This information includes audited financial statements, internal unaudited year-to-date financial statements, management letters, responses to the management letters, and footnotes to the financial statements. They consider it essential that the financial information they receive is prepared in accordance with generally accepted accounting principles (GAAP) and audited by a CPA firm with a national reputation. They want to follow the most business acceptable definitions since this same information will be used for the formal bond offering.

Cal-Mortgage does not use the hospital financial and utilization data reported to OSHPD by hospitals as part of the application process. The information is not timely enough to meet its needs, and does not comply with the business standards described above. As part of the application process, Cal-Mortgage requires the last audited financial statements, with the prior three years of historical data, projected forward. The OSHPD financial statement presentation differs from that required by CPAs as part of their audit process.

Once a hospital's application is approved and a loan is made, an on-going review and analysis process begins. Cal-Mortgage requires the hospital to provide internal quarterly financial statements, and year-end audited financial statements with the related management letter and the response to the management letter. They *do* use OSHPD disclosure report data in their monitoring process, but usually when there is a concern regarding an existing loan, and not on a regular basis. For example, Cal-Mortgage may want to compare the *expected* utilization patterns projected by the hospital's feasibility study with the *actual* utilization patterns reported on the OSHPD disclosure report over time.

Hospitals are not a significant portion of Cal-Mortgage's portfolio. There is not much information that OSHPD could collect that would be helpful because of the specific information requirements discussed above, some of which is pre-

pared by outside independent auditors. These are one-time projects and data is required only for hospitals that choose to participate in the process.

Beginning on January 1, 2000, Cal-Mortgage will be required to evaluate the Community Benefits reports submitted to OSHPD by hospitals which have a loan underwritten by their program. This is to ensure that the project is consistent with the hospital's community benefits plan. In addition, this new law requires each hospital to serve a specified percentage of eligible Medicare and Medi-Cal beneficiaries. Cal-Mortgage would like to see OSHPD collect the number of Medicare and Medi-Cal eligibles by Health Service Area to help it meet this requirement.

The Cal-Mortgage staff did want to note that the OSHPD data reporting customer service division has improved the accessibility of information by providing data electronically. Also, the staff in the unit has always been very helpful.

Finally, they recommended that OSHPD consider collecting data on Primary Care Clinics, which are a significant portion of their portfolio.

Healthcare Information Resource Center

Contact: Ms. Diane Dargan
Manager

Ms. Kathy Bolin
Data Consultant

The Center is responsible for the production and sale of the OSHPD "data products," including the OSHPD publications. The following publications are based on the three OSHPD reports covered by this project:

- "Individual Hospital Financial Data for California" (Annual Disclosure)
- "Aggregate Hospital Financial Data for California" (Annual Disclosure)
- "Quarterly Individual Hospital Financial Data for California" (Quarterly Report)
- "Quarterly Aggregate Hospital Financial Data for California" (Quarterly Report)

The "Annual Utilization Report of Hospitals", based on the Annual Utilization Report was discontinued in 1996 and replaced with equivalent information available on the Internet. The Internet information is in the form of two downloadable text files that can be read by commonly used spreadsheet and statistical software packages. The files contain the complete reports of each complying hospital for a given calendar year.

Approximately 75 copies are produced of each publication. This is sufficient to cover standing orders and occasional sales. The publications were designed with input from a committee representing users and the hospital industry. Some redesign is needed for changes in reporting requirements starting in the year 2000. The redesign will rely on input from the Health Data and Public Information Committee. If further changes in reporting–such as consolidation of some reports, or elimination or addition of data items on current reports–are implemented as a consequence of this project, major publication redesign may be needed.

The Center also provides hard copies of individual hospital reports and responds to custom requests for data. Its Hospital Annual Financial Data Internet file contains 225 selected data and calculated items derived from Hospital Annual Disclosure Reports filed with OSHPD. The data are for hospital report periods ending January 1 through December 31 of a given year. The data items include

basic hospital demographics; financial statement items, including assets, liabilities, revenues, and expenses; utilization data, including patient days, discharges, and outpatient visits; and labor information.

Currently the Center does not produce any issue-oriented informational publications for legislators, press, consumers, etc. The staff has given some consideration to doing so but there are no specific plans at this time. The staff feels that any steps in this direction will have to rely heavily on the technical support of the Accounting and Reporting Systems Section.

The Center is also responsible for the distribution and sale of the electronic products based on the Annual, Quarterly and Utilization Reports. The Center receives occasional inquiries from data users regarding problems with the data. The inquiries are generally referred to Accounting and Reporting Systems Section.

Hospital Community Benefit Program

Contact: Elsa O. Murphy
Program Manager

The Hospital Community Benefits Program resulted from legislation (Senate Bill 697, Chapter 812, Statutes of 1994) concerning reporting of community benefits of non-profit hospitals. Under the law, affected hospitals are to perform a community needs assessment every three years and report annually on a community benefits plan. The report is due 150 days after the end of the hospital fiscal year. The hospitals required to report are non-government not-for-profit hospitals, excluding Shriners hospitals and small and rural hospitals. This is a total of over 200 hospitals.

Community benefits are reported by the following categories:

- Medical care services
- Other benefits for vulnerable populations
- Other benefits for the broader community
- Health research, education and training programs
- Nonquantifiable benefits

The reports were first filed for hospital fiscal years that began on or after January 1, 1996. Therefore, the first reports were received in 1997. The legislation sets forth the elements of the reports to OSHPD but does not dictate the format or structure. However, the program provides a recommended outline that hospitals may use for their reports. Murphy receives many calls from hospitals that would prefer a standardized format for reports. In fact, she intends to put together an advisory group to discuss standardization.

The reports are available to the public upon request. Because there is no standard format, no computerized database of information is maintained.

Licensed Services Data and Compliance Unit

Contact: Michael Derrick
Manager

This unit is part of the Accounting and Reporting Systems Section of the OSHPD. The unit is responsible for collecting and disseminating utilization data from hospitals, long-term care facilities, primary care clinics, specialty clinics, home health agencies and hospices. Data are collected in the form of Annual Utilization Reports specific to each of these facility types. The reporting is mandated by Section 127285 of the California Health and Safety Code.

The Annual Utilization Report of Hospitals (AURH) forms for a given calendar year are mailed to facilities toward the end of the year. The reports should be completed and filed by February 15 of the next year, but only 50-60% of hospitals meet the deadline. Most remaining reports are filed shortly after the deadline, but some are as late as May and require follow-up from OSHPD. The reports are submitted in hard copy format.

Reports are keyed in for electronic processing. (A private company under contract with OSHPD keyed in the 1998 data.) When this is complete, the OSHPD computer system generates error reports that flag arithmetic errors and logical inconsistencies. The unit staff performs extensive follow-up work contacting hospitals to correct the errors. Derrick indicated that most of these errors could be eliminated if data were submitted in electronic format, as the edits could be made at the source hospital with standardized software. This would free unit staff for more sophisticated quality control, such as checking the historical consistency of the data at the hospital level. This is now only performed on a limited basis. It should be noted that the unit is moving in the direction of electronic data submission for other provider groups and is contemplating doing the same with hospitals once recommendations emerge regarding the possible consolidation of the AURH with the Hospital Financial Disclosure report.

Once follow-up work is completed, the corrected data are used to generate a quality control report that allows the unit staff to identify inconsistencies with historical trends at the aggregate state level. The inconsistencies are analyzed to detect possible remaining gross errors in individual reports. The final version of the corrected reports is forwarded to the Healthcare Information Resource Center for distribution to the public. Generally, this occurs in June or July, *i.e.,* the data are made available approximately six months after the end of the reporting period.

The AURH requires significant staffing. Derrick estimates that two full-time analysts and one staff service analyst work full time on this report, while an office technician devotes one half of his or her time. Derrick himself spends 65-75% of his time on the AURH. In addition, a number of student interns equivalent to approximately four FTEs work on the report.

From his own and his staff's contacts with providers, he has gained the impression that hospitals regard the AURH not so much as a burden but as an annoyance. This report is perceived to overlap with other data collected by OSHPD (financial disclosure and discharge data). There have been very few inquiries from data users concerning data problems.

There was an extended discussion of the reporting requirements, the possible reasons for collecting the AURH data items and the use of some of the items. Derrick indicated that to his knowledge some of the items may not be used and may not have much significance in today's health care environment, *e.g.,* data on megavoltage machines. He feels the public need for accurate and comprehensive hospital information may be better served by replacing some of the current AHUR data items with patient diagnosis, procedure and demographic information derived from the discharge reports. This would allow for more flexibility, as preset AHUR categories such as age intervals would be replaced with patient count by actual age. It would also allow more uniformity; AHUR categories that may be subject to interpretation, such as type of care, would be replaced by actual diagnosis/procedure data.

OTHER AGENCIES

California Medical Assistance Commission

Contacts: Holland Golec
Senior Hospital Negotiator

Fred Shelton
Research Director

Phil Taffet
Research Associate

The California Medical Assistance Commission (CMAC) is primarily a data user; it does not independently collect data from hospitals in a systematic fashion. Accordingly, there are no specific recommendations concerning collection of data from hospitals.

However, the CMAC staff makes extensive use of data collected by other state agencies and has some specific recommendations:

- Quarterly Financial and Utilization Reports should have, at least, long-term care demographic, revenue and expense information broken out separately. Ideally, information should be available by service line.
- Charity care and bad debt should be reported more completely and consistently to allow better comparisons of hospitals.
- The reporting of County Indigent Program revenue and utilization appears to be inconsistent among hospitals.
- The detail that will be available on managed care patient revenue by payer category will be of benefit.

CMAC is also concerned about the reporting and release of specific hospital data elements that they believe could influence their ability to negotiate hospital contracts. They recommend the following in this regard:

- Medi-Cal contractual adjustments and net revenue should continue to be reported in a combined fashion for inpatient and outpatient services on the Hospital Annual Disclosure Report. Thus, data users will not be able to determine the contract rate for inpatient services.
- If additional detail were provided on Medi-Cal payments, they would be concerned about discretely identifying amounts that are negotiated payments. This includes supplemental funds for medical education or through the program commonly referred to as SB 1255. They do not object to separate reporting of funds under the SB 1732 program (Medi-Cal Construction, Renovation and Replacement Program) because these payments are not determined through negotiations.

The CMAC negotiates contracts with hospitals for inpatient hospital services to Medi-Cal patients. In addition, CMAC also negotiates contracts with various other entities, such as Health Maintenance Organizations, to provide services to Medi-Cal eligibles through at-risk, prepaid contracts and other non-fee-for-service arrangements.

In the course of its negotiations, CMAC requests certain information from the hospitals; however, not all of these data are created by the hospitals for CMAC. Instead, the information is provided to the hospitals by such agencies as the Department of Health Services' Licensing and Certification Division, or is data from reports that hospitals prepare and submit to other state agencies. Some reports could be collected from other state agencies by CMAC, but CMAC believes information obtained directly from the hospital is apt to be more current.

The OSHPD reports utilized by CMAC include the Quarterly Financial and Utilization Reports, the Hospital Annual Disclosure Report and the Annual Utilization Report of Hospitals. The Hospital Annual Disclosure Report is used primarily for utilization data but CMAC has recently depended more on the Quarterly Financial and Utilization Report for this information. The Hospital Annual Disclosure Report is used primarily for the summary hospital information in OSHPD hard copy printouts. The detailed information is not normally reviewed by CMAC. Of course, from time to time, different data elements from the reports are used.

The concerns of CMAC are primarily over timing, because the information from OSPHD may not be as current as is needed. Also, the quarterly reports are not as useful as CMAC would like because of the collapsing of information. CMAC would prefer more detail in the report by the lines of services provided. Particularly troubling is the inclusion of long-term care and acute psychiatric care expense, revenue and demographic information along with the general acute

care information. The effort by OSHPD to separate managed care information by payer will be of use to CMAC when it is has been fully implemented through the cycle of hospital fiscal year-ends and is available to data users.

CMAC has from time to time investigated issues concerning charity care and bad debt expense and is concerned about the completeness and accuracy of this reporting to OSHPD. Thus, it would like more consideration given to this area of reporting. Similarly, it appears the county-owned hospitals report their indigent care services differently. Some county hospitals report charity and bad debt along with County Indigent Program revenue. Other county hospitals do not report any charity and bad debt; it is assumed this is included in the County Indigent Program category.

CMAC also uses other reports that involve data provided by or about hospitals. These include Licensing and Certification data, Medi-Cal cost reporting data (provided by the Audits and Investigations Division of the Department of Health Services), Medi-Cal paid claims information and Medi-Cal managed care reports.

California State Auditor

Contact: Catherine Brady

Representatives of the State Auditor rarely use OSHPD data, and then only on an as-needed basis to perform audits required by government standards or in response to a specific audit requested by the legislature. The State Auditor does not collect any hospital-related data.

Audits of hospitals are infrequent, although two performance audits were performed during the past two years. Both audits were requested by the legislature and both involved an examination of the merger between UCSF and Stanford Hospitals. OSHPD data were used to compare the performance of the two hospitals in question to other California hospitals.

The OSHPD database has also been used for source information in audits involving the Cal Mortgage Insurance Program.

State Auditor staff recognize that OSHPD data are not generally audited and therefore the ultimate accuracy of these data are dependent on reporting by hospitals. Brady reports satisfaction with access to the OSHPD data system. The State Auditors office has found OSHPD staff to be helpful and supportive in responding to requests for their specific data needs.

The State Auditor staff had no recommendations.

Department of Mental Health

Contacts: Kathy Styce
Stan Johnson

Mental Health Services are monitored and evaluated with the use of at least three different data reporting mechanisms.

The first system focuses on Short-Doyle Medi-Cal funds. Cost reports are completed annually to account for and determine provider reimbursement. Each legal entity receiving mental health funds from a county government is required to report to the county using a Short-Doyle Cost Report (attached). Each county then coordinates a report accounting for all Short-Doyle funds expended in its jurisdiction. It is important to recognize that data reporting is on a legal entity basis only. Individual providers such as clinics, hospitals and outpatient mental health centers do not report unless they are an independent, freestanding legal entity. Therefore, it is impossible to determine site-specific costs for multi-site providers. The Short-Doyle cost report contains only data related to county-funded mental health services. Department of Mental Health staff indicate that only about 24 hospitals statewide report data through the Short-Doyle cost reporting process.

The Short-Doyle Cost Report is used by the Department of Mental Health to evaluate costs per unit of service, as well as trends on the volume of mental health services provided at the county government level. Short-Doyle funding recipients submit interim patient claims data to the Department of Mental Health for screening and review. These claims are then forwarded to the Department of Health Services, which operates an in-house data system for processing and paying claims. A Short-Doyle Cost Report is then submitted at year-end to for final payment settlement. Interim payments are based on projected cost per unit of service, up to the maximum allowable payment for each specific service type.

Providers of mental health services that are not funded by Short-Doyle participate in the standard Medi-Cal payment system. Their claims are submitted to EDS for processing and payment. In the case of hospitals, services and payments are then annually reported using the Medi-Cal Cost Report and OSHPD reporting systems. In contrast to Short-Doyle funds, these data do provide a site-specific service and payment tracking system.

Mental health services provided in State Hospitals are not accounted for by the Short-Doyle Cost Report, Medi-Cal Cost Report, or OSHPD reporting systems. State Hospital services are funded separately from all other services men-

tioned above. These mental health services receive a distinct budget line item for all aspects of operation. The Department of Mental Health operates an internal hospital information management system specific to the State Hospital system.

The Short-Doyle Cost Report allows the Department to monitor, evaluate and compare costs associated with operating mental health programs. Cost reports provide sufficient detail to formulate trend analyses on types of service, location of service, cost per unit, type of client and other factors. They also allow the Department of Mental Health compare all counties receiving such funds.

No standard reports are published with the Short-Doyle Cost Report data. Limited automation of the process has been a major factor hindering the ability to publish any standard reports. Until recently, all Short-Doyle data were manually keyed into an Excel spreadsheet. These data are then used primarily for internal Department of Mental Health purposes, including budget preparation. The Department of Mental Health also responds to specific requests for data from the legislature or other state departments. There are few requests for public disclosure of Short-Doyle data, even though the data are public.

The Department of Mental Health has used OSHPD financial and utilization data, but only infrequently. The same is true for data collected and reported by the Department of Health Services. Mental Health more frequently uses population demographic data reported by the Department of Finance. On occasion, the Department of Mental Health has considered using OSHPD data to attempt to quantify the universe of mental health service. Its lack of automation has limited the department's ability to examine total services and costs at a provider-specific level. The OSHPD data and DHS data have been used to help maintain Mental Health files on the various legal entities that report through the Short-Doyle process.

The Department of Mental Health would like more capability to use non-departmental data in conjunction with its own data for special studies. For example, Department of Social Services data and Department of Health Services data might be used to study costs and services provided to mentally ill persons in foster care. The Department of Mental Health has no way of knowing the number of such persons, and what services are provided through Short-Doyle funds or other sources. The ability to conduct special studies might reduce duplication and improve coordination of service.

The Department of Mental Health has had problems integrating data sets at the state and county levels. Substantial effort has been expended to develop a set of common core identifiers for linking county level client information to state data collection processes. If a common set of core data elements were collected

by each department at the state level, it would potentially be possible to track individual clients through all elements of the state health, mental health and social service systems. If each reporting entity were to electronically tag client-related records with common identifiers, Mental Health could use data to develop a client identification profile. This could be useful in tracking physical health issues, admissions and discharges, court status and other service relevant information. These data would be helpful in developing mechanisms for outcome reporting and possibly client satisfaction data.

Emergency Medical Services Authority

Contact: Dan Smiley

The State Emergency Medical Services Authority (EMSA) has just recently begun to require data submission from the 33 local or regional emergency medical services authorities throughout the state. The data are related to prehospital care services provided by paramedics and emergency medical technicians. Data elements include case identifiers, transportation factors, time elements, patient demographics, clinical care data, disposition, and receiving hospital code. A complete listing of the 58 data elements is attached in the Appendix for reference.

EMSA employs four full-time equivalent employees, and has total operating expense of approximately $400,000 a year, for data collection and processing. EMSA has some grant funds for developing automated linking of local EMS data collection into a more comprehensive statewide system.

EMSA has used OSHPD data on occasion for specific analyses of services within its area of jurisdiction. For example, hospital-specific financial and utilization data were used to study trauma center costs. These data were useful in evaluating the impact of trauma center designation and de-designations.

Because EMSA focuses primarily on clinical services (prehospital emergency care), it is most interested in data collection and management approaches that permit a comprehensive evaluation along the continuum of care. Its database now focuses on the prehospital phase of service and terminates with the hospital admission of a patient. This does not allow EMSA to evaluate the cost effectiveness of prehospital care, because ultimate patient outcomes, costs and other data are never captured during the prehospital phase of care. For example, EMSA cannot identify an admitting diagnosis or costs associated with emergency department care of patients delivered to a particular hospital.

EMSA believes it would be useful to be able to link its database with additional data elements captured in the OSHPD utilization and financial systems. EMSA's vision is of a system using common root patient identifiers, so that an emergency case could be tracked through the two data systems. This would enhance its ability to study EMS patient outcomes and cost-effectiveness. EMSA would like to study whether or not shorter emergency response times decrease hospital length of stay, reduce costs or improve patient outcomes.

EMSA indicated that OSHPD data were reasonably accessible. In addition, EMSA management found the OSHPD staff to be cooperative and helpful in fulfilling their requests for data support.

EMSA did express some concern about the timeliness of OSHPD data–which are almost two years old by the time they are obtained from OSHPD. These time lags present problems. EMSA ends up matching earlier hospital financial or utilization data with very current prehospital care data. Additionally, if the EMSA root identifier linkages were ever developed, EMSA might have to wait a substantial period of time to track a patient from the prehospital care setting through the hospital course of care. EMSA also expressed some concern about the accuracy of data self-reported by hospitals in the OSHPD data system.

EMSA expressed a strong interest in working with OSHPD and other state agencies to identify ways to better integrate the exchange of data in different data collection systems. At present, EMSA views most internal agency data center staff as oriented to collection, processing and security of data. This mindset runs counter to developing approaches that facilitate linkages across departments within state government. From the EMSA perspective, there are as many as six or seven different state agencies that could link existing databases to enhance the usefulness of information already in existence.

We did not further explore the other six or seven data systems mentioned by EMSA since most seemed only remotely relevant to this specific project. Among the state agencies mentioned by EMSA were Cal Trans and the California Highway Patrol.

It may be useful for OSHPD to explore means to link the EMSA prehospital database with the discharge data system. Such a link could enable the patient tracking studies envisioned by EMSA.

State Controller's Office

Contact: Nancy Valle

Government Code Section 53891 requires the completion of the Annual Report of Financial Transactions of Special Districts for all California "local agencies." Local agencies are defined as any city, county, any district, and any community redevelopment agency required to furnish financial reports pursuant to Section 12463.1 or 12463.3 of the Government Code.

The report has been designed for all "local agencies," not specifically hospital districts. There are approximately 4800 "local agencies," only 78 of which are hospital districts. Section 53891.1, however, modifies the reporting for hospital districts by allowing them to replace the report of all financial transactions with the specific report pages from the OSHPD annual disclosure report. These are then supplemented with detailed balance sheet related information specified in Sections 53892 and 53892.2 of the Government Code, and year-end audited financial statements.

Specifically, the following type of information is collected in detail on the Special District's Annual Report:

- Statistical information related to tax assessments, revenues and taxation that may be needed by any Senate or Assembly committee on revenue and taxation.
- Specific information related to any applicable general obligation bonds, revenue bonds, improvement district bonds, limited obligation bonds and special assessment bonds.
- Specific information related to all lease-obligations.
- Detailed information related to any construction that is financed through an arrangement with the state or federal government.

The State Controller's report is due four months after the end of the hospital's fiscal year, with no allowances for extensions. If a State Controller's report is not filed within 20 days of written receipt of a notice of failure to file, a fine may be assessed. Since most hospitals request and receive extensions from OSHPD, the State Controller's Office currently does not enforce fines for late filing that are within the prescribed time deadlines set by OSHPD.

The information is transmitted in hard copy, and reviewed by a desk audit process. There are currently two staff assigned to the hospital district reports,

although they also review reports from other types of special districts. The data is reviewed for reasonableness, completeness and for consistency between years. It is then entered into a database for further internal edits. The Controller's office is currently seeking a contractor to develop a system for the electronic submission and editing of this report.

The Government Code does not explain why the data are collected, who uses the information and for what purpose, or whether the data elements are still necessary to collect. An annual publication of about 1,000 pages summarizes the data from all special districts, and this is the form in which data are made available to the legislature. The Controller's office occasionally provides copies of the actual reports and prepares special requests using the collected data. These special requests usually do not involve hospital reports. A summary of the reporting pages and other information regarding these reports can be found on the state and local government page of their web site (www.sco.ca.gov). Valle indicated that her office does not obtain information from other state agencies, except from OSHPD to verify the status of the district hospitals.

She was not opposed to OSHPD collecting the required information directly from hospitals, performing the edits and then providing her office with the necessary information for the annual publication. However, for this to occur a change in the government code would be required. Her main concern was whether OSHPD could provide the edited information in a manner that would meet the State Controller's Office's deadline for their publication.

Part 5
Interviews with Data Users

TABLE OF CONTENTS

THE INTERVIEW PROCESS AND A SUMMARY OF RESULTS

User Sample

Twenty-four data users have been interviewed regarding their experiences with the three OSHPD databases under investigation, and their recommendations for change. The interviewees were drawn from six groups as follows:

- Consumers
- Employees
- Employers
- Researchers
- Consultants
- Purchasers
- Providers

The sample was selected on two bases: (1) from a list supplied by OSHPD of purchasers of the Annual Report or Annual Disclosure Report files on tape, CD-ROM or cartridge; and (2) by referrals from other users believed to be knowledgeable and/or frequent data users. The table below lists each data user by the six classifications above.

This group is not intended to be a random sample representative of the universe of data users. It is probably biased toward the more technically sophisticated, and the more frequent, data user. This type of data user, by being relatively familiar with the data's nuances and applications, can provide the most valuable input to this project.

The selected users were first contacted by phone. If they agreed to an interview, they were then sent a letter, which included a summary of the issues and data to be discussed. They were then interviewed by phone. Several individuals

contacted turned out to be unfamiliar with the data, others were non-responsive. The one refusal listed below represents an organization that uses the OSHPD data, and is involved in OSHPD's Cal-Mortgage program. These users who could not be interviewed are listed in a separate table.

Table 1: Data Users Interviewed According to User Type

Type of User	Name	Organization	Status
Consumers	Julio Mateo	Consumers Union	Interviewed
Consumers	Chester Horn	Attorney General	Interviewed
Consumers	Gilbert Ojeda	Calif. Program on Access to Care	Interviewed
Employees	Fred Seavey	SEIU	Interviewed
Employees	Carolina Briones	SEIU	Interviewed
Employees	Dan DeMoro	CNA	Interviewed
Researchers	Marta Wosinska	UC Berkeley	Interviewed
Researchers	Leonard Finocchio	UCSF	Interviewed
Research-ers	Jeffrey Gould	UC Berkeley	Interviewed
Researchers	Jeanne Coffey	UCSF	Interviewed
Researchers	Linda Remy	UCSF	Interviewed
Researchers	Joanne Spetz	Public Policy Institute of California	Interviewed
Researchers	Leslie Eldenberg	University of Arizona	Interviewed
Consultants	Lucy Johns	Health Care Policy & Plan-ning	Interviewed
Consultants	George Hovis	PricewaterhouseCoopers	Interviewed
Consultants	William Viergever	Viergever & Associates	Interviewed

Type of User	Name	Organization	Status
Consultants	Dara Caplan	The Lewin Group	Interviewed
Consultants	John Mayerhofer	John Mayerhofer, CPA	Interviewed
Purchasers	Kenny Deng	Blue Cross of California	Interviewed
Purchasers	Holland Golec	CMAC	Interviewed
Providers	Alan Underwood	Catholic Healthcare West	Interviewed
Providers	Santiago Munoz	California Association of Public Hospitals & Health Systems	Interviewed
Providers	Rian Romoli	Kaiser	Interviewed
Providers	Heather Leicester	California Children's Hospital Association	Interviewed
Providers	Pika Sothi	UC Systemwide Administration	Interviewed

Table 2 Data Users Contacted but not Interviewed According to User Type

Type of User	Name	Organization	Status
Consumers	Shelly McKewen	California Women and Children	
Consumers	Melinda Parras	Health Access	
Employers	Jim Loftin	CalPERS	Do not use data
Employers	David Hopkins	Pacific Business Group on Health	

Type of User	Name	Organization	Status
Employers	Lee Dickerson	First Health	Do not use data
Employers	Michael J. Riley	International Foundation of Employee Benefit Plans	Do not use data
Researchers	Robert Seidman	San Diego State University	
Researchers	Richard Scheffler	UC Berkeley	
Researchers	Allison Evans Cuellar	UC Berkeley	
Consultants	Frank Jackson	Cain Brothers	Refused
Consultants	Bob Zeller	Arthur Andersen	
Consultants	Veronica Horton	Dun & Bradstreet	
Providers	Ted Sirota	Barlow Hospital	

Scope of Interviews

The general scope of the interviews is set forth in the following table:

Table 3: Scope of Data Users Interviews

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data			
Frequency of Use: Often Seldom			
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other			
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other			
Recommendations for Change			

In addition, interviewees were asked their opinions of data accessibility, adequacy of input into OSHPD decision-making regarding data reporting, and, based on their use of the various reports, the desirability of consolidating the Annual Utilization Report and the Medi-Cal Cost Report into the Annual Disclosure Report. They were also asked what other hospital data they use provided by other state agencies.

Summary Results

This section follows the format of the above table.

1. Access Mode

The users' access modes vary among users and reports accessed. Of the respondents indicating use of the Annual Report, one accesses the data through publications, a few through the Web Site and most through purchasing the data in electronic form. This is surprising since the full Annual Report is available for download on the Web Site. The breakout is similar for the eight users of the Quarterly Report.

With respect to the Annual Disclosure Report, half obtained the data through purchasing CD-ROMS, cartridges or tapes, one quarter through the Web Site, a few through publications or the "raw" data (printouts of individual reports prepared by OSHPD). Several respondents access the data through more than one medium, hence the number of "users" referred to here does not match the sample size. The preponderance of users purchasing CD-ROMs or tapes most likely reflects our selection criteria. Moreover, this is the only way to obtain the full Disclosure Report database. Only a summary file of approximately 250 variables is available on the Web Site.

2. Frequency of Use

Of the sampled users, the Disclosure Report was used most frequently, reflecting our selection method. Certainly this is the most complex and comprehensive report, and the report most often referred to when considering consolidation, reporting burdens on hospitals and redundant reporting. All but a few are frequent Disclosure Report users. With respect to the Quarterly Report, over half indicated frequent use. Annual Report users were fairly evenly split between frequent and infrequent.

3. Reasons for Infrequent Use

One obvious reason for infrequent use of any of the reports is inapplicability to particular projects. With respect to the Quarterly Report, infrequent use is at-

tributed to lack of detail and less accuracy than the disclosure Report. Infrequent use of the Annual Report mainly reflects its lack of any financial data, including payer source. The few users indicating infrequent use of the Disclosure Report cite inconsistent fiscal years and little need for its high level of detail. One user found the CD-ROM Annual Disclosure too difficult to use and did not purchase it again.

4. Data Categories Most Often Used

Given the relatively brief nature of the Quarterly Report, the most-used data categories are more relevant to the other two reports. The least popular data categories in the Annual Report involve long-term care and demographic data on long-term care patients, although some respondents use these categories. It appears that most, if not all, data categories of the Disclosure Report are used. Data categories used, in varying degrees, include: hospital descriptions, service inventory, board composition, medical staff profile, related organizations, inpatient and outpatient utilization, payer mix, profit and loss, uncompensated care, balance sheet, cost center revenues, costs and volume, and staffing and payroll.

5. Problems Identified

Very few problems were identified for the Quarterly Report and the Annual Report. The former has an accuracy problem because the report is filed before hospitals typically accumulate all their year-end data. Other problems identified also apply to the Disclosure Report (*i.e.*, exclusion of data on individual Kaiser hospitals, non-uniform reporting of charity and incomplete data on disproportionate-share hospitals' transfer payments and other data on public hospitals' revenue sources). Few problems were pointed out for the Annual Report. One user indicated a problem in recording intra-hospital transfers.

The Disclosure Report was the focus of concern. The most frequently mentioned problems are as follows:

- Timeliness (between the close of a hospital's fiscal period and the availability of a complete cycle of data)
- Uniformity (especially regarding charity and bad debts)
- Accuracy and consistency with same data reported elsewhere (e.g., OSHPD discharge data)
- Mathematical errors (some columns don't add to the reported totals)
- Inconsistent reporting of disproportionate share transfer payments
- Major programming difficulties in dealing with reports over time

- Large data files that are not user friendly
- Insufficient enforcement by OSHPD of inaccurate reporting or non-reporting; sanctions too mild for reporting delays
- Exclusion of Kaiser hospitals from individual hospital reporting
- Typos and spelling inconsistencies in open-ended fields, including confusion between hospital owner and system affiliation
- In cases of ownership change, partial-year reporting is confusing
- Insufficient data on medical practices, surgery centers and other businesses owned by hospital systems
- Confusion between zeroes and missing data
- Lack of a hospital system indicator

6. Recommended Changes

Again, most recommended changes relate to the Disclosure Report. Recommended changes to the Disclosure Report include the following:

- Quicker turnaround, to enable more meaningful data analysis.
- Add data on the number of full-time and part-time staff according to occupational category and department, in addition to current reporting of productive hours. This would provide proxies for continuity of care based upon an assumption that the fewer individual nursing staff assigned to an individual patient the more familiar the nurse is with that patient's problems.
- Indication of the collective bargaining status of certain classes of employees. No publicly available database provides information on the number of employees covered by collective bargaining agreements in individual hospitals or groups of hospitals. Such data would enable research on the relationship between unionization and hospital costs and quality of care.
- Community benefits reported by not-for-profit hospitals to OSHPD as part of their responsibilities under SB 697 should be standardized and added to the Disclosure Report. Such standardization would enhance the ability to assess each hospital's contribution to its community, and to compare such contributions across hospitals and communities.
- Make the full database available in Excel files, or in SAS files (a commonly used statistical analysis format), to improve access to the full database.

- Provide better guidance to data file users regarding changes in variable locations, names and definitions over time
- Insure complete and accurate reporting
- Increase financial penalties for late reporting due to bad faith. There were reports of hospitals under public scrutiny intentionally delaying report submission.
- Include summary pages in data files, to enable quick analysis and to provide control totals.
- A uniform definition of charity should be adopted. It was also recommended that charity be identified according to inpatient, outpatient and emergency services. The reporting of charity is haphazard, varies widely between the Quarterly and Annual Disclosure Reports, and even varies widely within the Annual Disclosure Report as filings are amended by hospitals. A uniform definition based on federal poverty standards would be a major improvement. Given the Attorney General's authority to approve conversions of not-for-profit hospitals to for-profit status and the linkage of charity care and SB 855 payments, uniform charity reporting is a major public policy issue.
- Add more data on reproductive services. This is an issue in some communities.
- Additional data on SB 1255 and SB 855 revenues and transfer payments. Currently, on both the Disclosure Report and the Quarterly Report, total transfer-payment reporting is inconsistent; leading to grossly inflated net incomes for some public hospitals.
- Include "product-line" breakouts [i.e., full costs and revenues (routine and ancillary) allocated according to bed type]. This would enable more appropriate comparison of costs between diverse hospitals, on a program-by-program basis.
- Include individual Kaiser hospitals. One of the State's largest hospital systems is excluded from individual hospital reporting in the Annual Disclosure and Quarterly Report systems. This greatly compromises these systems.
- Distinguish zeroes from missing values, to eliminate one possible source of error in data interpretations.

- Develop uniform definitions of hospital systems instead of using open fields. With the current open fields, identifying parent hospital systems is extremely time consuming due to minor word variations and spelling differences.
- To the maximum extent feasible, replace open-ended fields with categories. This would make these data items far more useful.
- Add a "Home Office Report" for hospital systems identifying their affiliated health-care business (e.g., medical groups, HMOs, nursing homes, home health agencies, surgery centers). With increased levels of vertical integration, hospital organizations are involved in provision of a greater array of services, which is not captured in the current reporting systems.
- Report deductions from revenue for each major payer, separated by inpatient and outpatient. This would enable analysis of the impact of managed care penetration on hospital prices. (This would have to be accomplished in a manner that does not enable derivation of a hospital's confidential Medi-Cal per-diem rate.)
- Add further detail on managed care payers (coming in next reporting cycle).
- Include a case mix index variable on the Disclosure file, individual report summary pages and publications, calculated from the discharge data. This would provide a fuller picture of the hospital in summary form.
- Add area-wide demographic data to the publications and individual report summary pages. This would provide a fuller picture of the hospital and its market in summary form.
- Add data describing the local health system to individual report summary pages (e.g., market concentration, area-wide occupancy, per-capita health resources). This would provide a fuller picture of the hospital and its market in summary form.
- In publications, include tables with and without Kaiser. This would improve the accuracy of area-wide aggregates.

Some of the changes to the Annual Disclosure Report would obviously affect the Quarterly Report. The following changes were suggested for the Quarterly Report:

- Include individual Kaiser hospitals in the reporting system.
- Separate reporting of general-acute revenues, costs and volume.

- A uniform charity definition.
- Complete data on SB 855 and SB1255 revenues and transfer payments.
- Add a statement that the Quarterly data might not be as accurate as the Annual financial data.
- Make year-to-date and previous year data available in order to incorporate most, if not all, subsequent corrections.

With respect to the Annual Report, data users recommended the following relatively minor changes:

- Include variable names on files instead of codes
- Reduce the turnaround time
- Add patient demographic data to acute services

7. Other Issues

Interviewees were also asked general questions, such as their opinions on data accessibility, their level of input into OSHPD decisions regarding data reporting and the feasibility of consolidating some reports. They were also asked whether they use hospital data obtained by other state agencies. None of the users interviewed indicated use of hospital data provided by other state agencies. A large number, however, are users of OSHPD discharge data.

Regarding data accessibility, users were generally pleased with the OSHPD Web Site and the availability of the short Disclosure file on that site. Researchers, especially those dealing with many years of data obtained from the full files, urged further efforts by OSHPD to make the data bases more user friendly. With respect to input into OSHPD data policies, many believe there is room for improvement. One mechanism suggested is establishing a data users advisory committee. Some respondents reported problems in getting answers to technical questions from OSHPD. Others were pleased with staff responses.

When asked about consolidating the Medi-Cal Cost Report into the Disclosure Report, user responses were frequently favorable, as long as the Disclosure Report was not compromised. One respondent, however, opposed consolidation on the grounds that it could compromise the uniformity of the national Medicaid database.

Interviewees who use the Annual Report were also asked about consolidating it into the Disclosure Report and eliminating the Annual Report's long-term-care demographic data. In most cases (but not all), such consolidation would be ac-

ceptable if: (1) OSHPD would continue to prepare an Annual Report file, for download, that included data comparable to the current file; (2) data timeliness would not be compromised; and (3) demographic data would be extracted by OSHPD from the discharge data and input into the OSHPD-created "Annual Report" file.

Under this scenario, the only change that users would realize would be "Annual Report" data available on a hospital fiscal-year basis, rather than a calendar-year basis, as is the case currently. Assuming OSHPD could implement such a "seamless" change (*i.e.,* prepare a data file nearly identical to the current Annual Report, but derived from data obtained from the Disclosure Report and the Discharge Reports), eliminating the uniform calendar-year reporting period could cause problems for data users examining several years of data, especially with respect to individual hospitals.

INDIVIDUAL INTERVIEWS

The following tables summarize the results of the interviews with the data users. In some cases, there were multiple interviews conducted with the users. Because several of the data users were concerned about disclosure of their comments, the names of the individuals are not disclosed on the individual interviews.

Consumer 1

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Web	Web	No
Frequency of Use: Often Seldom	First time	First time	
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Beds, length of stay, revenue by payer, total revenue, charity, bad debts, balance sheet		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• Timeliness; doesn't know which source has more current data (CD, Web site, publications) • Uniformity/accuracy • OSHPD enforcement of inaccurate reporting or nonreporting		
Recommendations for Change	Separate charity between inpatient and outpatient. • ER charity should be added. • Require earlier determination of charity eligibility. • Put community benefit data on the web site. • More data on reproductive services.		

Data accessibility: Impressed with Web site, but confused over various paths to hospital data.

Input into OSHPD decisions: adequate. Should convene advisory group of data users.

Data from other State agencies: None

Major use: Report on charity care

Consumer 2

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Tapes and individual reports	Tapes	Tapes
Frequency of Use: Often Seldom	Often	Often	Seldom
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			Limited data, but useful
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Cost, revenue, profits, balance sheet No cost center data No staffing data		Doesn't use long-term care data
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Accuracy		
Recommendations for Change	• OSHPD should alert user community to data availability. • Data has to be preserved. • Need better outpatient data		

Data accessibility: Hasn't accessed in last few years.

Input into OSHPD decisions: Adequate based on friendships with OSHPD staff.

Data from other State agencies: None

Would like to see better availability of community benefits data.

Major use of data: Research into health services access.

Consumer 3

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Raw data (Printout summary pages)		
Frequency of Use: Often Seldom	Often		
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Not as accurate	Only interested in charity, Medi-Cal, indigent care
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	First two pages of summary report (charity, Medi-Cal County indigent care)		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	None		
Recommendations for Change	None	Add statement that highlights why data might not be accurate for certain categories	

Accessibility of data: No problem.

Input into OSHPD decisions: Hasn't tried

Other state agencies' data: none. But recommends that Community Benefits data reports be made uniform.

Major use: Community impact of not-for profit conversions.

Employees 1

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Small file from the web Raw data	Web	
Frequency of Use: Often Seldom	Often	Seldom	Never
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Accuracy regarding charity	Not aware of it
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Board composition Service inventory Utilization Payer mix Ancillary statistics Revenue, cost by cost center Balance Sheet Non-acute services		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Timeliness Accuracy Charity definition unclear System affiliation unclear		
Recommendations for Change	Quicker turnaround Uniform charity definition Clarify system definition		

Data from other State agencies: Health Facilities Authority filings, DHS licensing deficiency reports, OSHA workplace injuries, OSHPD Community Benefit reports.

Data accessibility: Chaotic when ordering data due to staff turnover.

Input into OSHPD decisions: Hasn't tried.

Employees 2

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD-ROM	CD-ROM	Web
Frequency of Use: Often Seldom	Often	Often	Often
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	All	All	Also use patient demographics
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	FY issue is troublesome in terms of explanation (i.e., requires complicated footnotes). Not a problem in terms of analysis. Uniformity Accuracy Exclusion of Kaiser and Shriners	Inconsistent with Annual Disclosure	Individual fiscal years would be tolerable
Recommendations for Change	Include Kaiser Include number of actual employees (i.e., bodies) in patient care, not just FTEs or hours. Include employee turnover	Include Kaiser	

Data accessibility: Wants more on Web site (more years). Input into OSHPD decisions: None, want some.

Data from other State agencies: DHS hospital closure data and Medicare cost reports from private vendor. Data consolidation (annual report or Medi-cal cost report): O.K. as long as doesn't disrupt trending analyses.

Major uses: Research on cost, quality, staffing.

Employees 3

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Web Raw data (since more current and accurate than publications)	Publications	
Frequency of Use: Often Seldom	Often	Seldom	
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Less accurate than Annual Disclosure	
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	P.3.1 related organizations, transfers to parent corporation cost, revenue, detailed financial, balance sheet, staffing, psychiatric and long-term care		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• Timeliness • Uniformity (charity) • Math errors (some columns don't add up) • Inconsistent reporting of DSH transfer payments		
Recommendations for Change	• Quicker turnaround • Uniform charity definitions. • Data on staff turnover and number of employees (not just hours or FTEs). • Better enforcement of charity reporting. • Develop standardized reporting of community benefits. • Note substantial change in services from previous year		

Major use: Union representation

Data from other State agencies: Submittals to the Health Facilities Financing Authority (audited financials and applications); and DHS Licensing files.

Data accessibility: Good, but would like revised disclosure data put on Web as it becomes available.

Input into OSHPD: Good. Staff are very helpful.

Researcher 1

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Web CD-ROM	Web Diskette (before Web)	Web diskettes (before Web) CD
Frequency of Use: Often Seldom	Often	Often	Often
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Pages: 1, 2, 4.1, 4.2, 4.3, 10, 21 Page 21 (staffing) very valuable, since match with case-mix data Uses page 2(1) Service Inventory non-acute (outpatient & psych)	Prepares standard reports on a quarterly basis	Uses all but demographic data
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• Too many filing delays. Page 10, departmental costs and revenues, inconsistent and incomplete. • Make data files more user friendly. • Very hard to deal with files over time, since versions change.		Would like to keep consistent time period
Recommendations for Change	•Put full version in Excel files. • Provide a map of changes from year-to-year (keep variable names constant). • Increase financial penalties for late filing (some hospitals intentionally file late when involved in controversy), • Satisfied with current data items. Concerned with accuracy and timeliness. • Insure complete reporting, especially on Page 10.		Include variable names on file, instead of just codes.

(See next page for additional comments)

Researcher 1 (continued)

Input into OSHPD reporting decisions: On list of people OSHPD consults, thus no problem.

Small disclosure file available on Web not useful since doesn't include staffing data.

No need to reduce reporting requirements, since hospitals already invested in necessary data systems.

Uses the OSHPD discharge data. Does not use hospital data from other State sources (but uses American Hospital Association and Health Care Financing Administration data files).

Access to data: Feels the research community is poorly served by the current methods of releasing the Annual Disclosure data. Researchers need to either have programming skills themselves or have access to programmers, as a significant programming effort is required to process the data. The problem is compounded by the changes in format and content over the years. In her opinion the problem could be resolved by generating SAS files (one file for each disclosure page but covering all hospitals and all years) and making the files available on the Internet.

Access to OSHPD staff: Has met with OSHPD staff to discuss the release of the disclosure data in SAS format. Does not feel the meetings were productive. She is particularly frustrated since it is her understanding that the OSHPD staff does generate SAS files that would meet most of her requirements.

Opposes product line accounting. She is particularly concerned with how staffing statistics would be reported under such a system.

Opposes changing the current utilization statistics. Feels that reporting accuracy of current statistics -and of other disclosure components—could be improved by more aggressive auditing by OSHPD.

Has no problems with consolidating the Annual Disclosure and the Annual Report of Hospitals.

Opposes the consolidation of Annual Disclosure and Medi-Cal cost reports as it could compromise the uniformity of the national Medicaid database.

Other issues: has found page 10 disclosure data missing for many hospitals. This could be caused by hospitals not reporting the supporting information on other pages.

Researcher 2

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	No	No	Purchase Diskette
Frequency of Use: Often Seldom	Never	Never	Often
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other			Days and discharges in the Perinatal and Intensive Care Newborn Nursery, primarily to identify hospitals providing these services. Used for conducting risk-adjusted infant mortality studies.
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other			Thinks timeliness is "terrific" (apparently referring to the time between ordering and delivery of diskette) Has noticed problems with accuracy by comparing with other sources (delivery numbers from Vital Statistics)
Recommendations for Change			None

Uses data on births and infant mortality from the Center for Health Statistics, California Department of Health Services.

Access to data is very good.

Did not feel the need to provide input to OSHPD staff.

Consolidation of the Annual Report of Hospitals with the Annual Disclosure would be a problem. A switch from the current calendar year reporting to a mixture of different hospital fiscal years will make it hard to match hospital characteristics to the calendar year data from the other source (see above).

Researcher 3

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Cartridges 1980-95		
Frequency of Use: Often Seldom	Using in two year project on governance	No	No
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		No governance data	No governance data
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Pages 0, 1, 3, 5, 8, 18		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Uniformity and accuracy. • Income statement: charity, missing values reported as zero. • Balance Sheet: spotty data, a lot of non-reporting of assets and liabilities. • Page 3A lot of typos, open-ended data fields should be replaced with categories and boxes. • Page 18: Zeros and missing values in administrative services, values don't add up.		
Recommendations for Change	• Distinguish between zeros and missing values (biggest problem). • Page zero, need uniform definitions of names of owners. • Open ended data fields (e.g., occupations of board members) should be changed to categories. • Need better editing of balance sheet		

Data accessibility: Waited several months for the data, some manual pages were copied wrong, difficult programming. But looking at 16 years worth of data.

Input into OSHPD decisions: Hasn't tried. Data from other State agencies: None

Use of data: Research project on hospital governance

Researcher 4

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Web Site (210 variable file)		
Frequency of Use: Often Seldom	Often		
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	• Hospital type, beds, owner, type of care • cost, revenue, balance sheet, charity, bad debts, donations, net income • Focus on uncompen-sated care and community benefits		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• No major problems, data very accessible. • Happy with Web site • Duplicate entries for hospitals that changed ownership		
Recommendations for Change	None		

Data from other State agencies: None

Data accessibility: Very good

Input into OSHPD decisions: Never tried

Major use: Study of uncompensated care and community benefits

Researcher 5

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Tapes CD-ROM		
Frequency of Use: Often Seldom	Often	No	No
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Doesn't contain staffing data	Doesn't contain staffing data
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Services inventory Descriptive data inpatient utilization No financial data staffing/payroll (look at specific routine cost centers)		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• Accuracy. • Confusion between hospital owner and system affiliation. • Timeliness • FY reporting when hospital changes ownership		
Recommendations for Change	OSHPD help to reconcile different years.• More user database (e.g., CD-ROM with SAS codes).• Add full and part-time personnel by occupation for at least some routine cost centers; distinguishing IP from OP. • Add data on collective bargaining status of employees		

Data accessibility: Good, but large files could be made more user friendly.

Input into OSHPD decisions: Only made informal contacts with staff.

Data from other State agencies: None, but use discharge data

Major use: Research on nurse employment

Researcher 6

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Cartridges CD-Rom		
Frequency of Use: Often Seldom	Often		
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Interested in financial statements	Interested in financial statements
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Income statement Balance sheet Board composition Staffing		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Uniformity and accuracy. Spotty data reporting, especially on the part of for-profits and public hospitals (income statement, balance sheet) Late years better than early years re: accuracy and completeness		
Recommendations for Change	Better enforcement of reporting standards		

Major use: Research on hospital finance, and impact of Board composition.

Data from other State agencies: No.

Data access: Very good.

Input into OSHPD policies: Hasn't tried

Researcher 7

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	All Mostly CD-ROM		
Frequency of Use: Often Seldom	Often		
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Doesn't contain data needed	Doesn't contain data needed
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	cost, revenue, patient days professional fees, administrative expenses, pp. 15-18		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Accuracy and incomplete reporting. Large data files very difficult to work with.		
Recommendations for Change	Front summary page on individual report printout has good overview. Would like it in electronic data files. On same page should add some area-wide data indicative of competitive pressures Should interface with DOC to include some HMO summary data.		

Input into OSHPD reporting policies: Talks with OSHPD staff, but not clear on access users have into decisions.

Data accessibility: Large data files should be more user friendly.

Use of data from other state agencies: None. Purpose of research: Doctoral thesis on hospitals' marketing and use of consultants, and effect on profitability.

Consultant 1

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD ROM and individual hard copy reports. Also INTERNET summaries and queries. Not much aware of any of the OSHPD publications	Internet	Indirect. Purchases reports from a firm MARKETING INSIGHTS which appears to use utilization data from AHR
Frequency of Use: Often Seldom	Often (hard copy individual reports & Internet). CD-ROM seldom (once?)	Seldom	See above
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Cost/Discharge, Cost/FTE, FTE/Discharge, Revenue Cost Information, mostly from Internet available files or queries		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Satisfied in all categories		
Recommendations for Change	Finds the CD-ROM difficult to use. The ad-hoc queries need improvement but could not be very specific. Would pay more to have individual reports in spreadsheet form (*e.g.*, EXCEL).		

Uses Marketing Insights reports combining OSHPD and MEDPAR (?--Probably OSHPD Discharge Data)

Consultant 2

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Publications and internet	Internet and disckettes	Publications, internet
Frequency of Use: Often Seldom	Moderately often (6-7 times a year)	Often	Seldom
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			Seldom relevant to the types of projects performed
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Staffing and payroll Utilization (days, discharges, Beds) Non-acute services Balance Sheet Statement of Income Payer specific cost and revenue	All	
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Timeliness--too far behind. While quite aware about uniformity and accuracy problems with individual reports, satisfied with the overall quality of the data. Feels it is unrealistic to have much higher expectations.	Problems with accuracy. Many of these problems are corrected by OSHPD but the corrections do not "flow" to users under the current approach to data release.	
Recommendations for Change		The year-to-date and previous quarter & previous year-to-date should be made available on Internet	

Does not use hospital data from other State data sources.

Supports consolidation of the Annual Report of Hospitals and the Hospital Disclosure Report

(See next page for additional comments)

Consultant 2 (continued)

Does not support the consolidation of the Medi-Cal and Disclosure reports. Concerned that hospitals may prepare the consolidated report with the intent of maximizing reimbursement. This may bias the disclosure database that is currently perceived as "clean" as it is not directly influenced by reimbursement incentives.

Suggested instead the consolidation of the quarterly and annual disclosure reports by adding several detail schedules to the fourth quarter quarterly report.

Supports simplifying the standards units of measures. Suggested that outpatient visits be replaced by "registrations", i.e., recording each daily hospital outpatient encounter as one unit, regardless of the number of departments visited.

Consultant 3

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Publications	Publications	Publications
Frequency of Use: Often Seldom	Seldom	Often	Seldom
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other	Doesn't need detail, fiscal year problem		Little need
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Mainly utilization statistics — total and by payer	Mainly utilization statistics — total and by payer	
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• Kaiser exclusion. • Non-uniform charity reporting. • Financing of county hospitals.	• Kaiser exclusion. • Non-uniform charity reporting. • Financing of county hospitals	
Recommendations for Change	• Add an appendix to publications, including DOF population projections by age. • Add case-mix index to each hospital. • Develop estimates of total health expenditures	Add summary tables at end of publications, with and without Kaiser aggregates. In some tables, should exclude specialty hospitals.	

Data accessibility: Publications are O.K., but ought to have a narrative interpreting the data and the policy implications. Need more of a consumer orientation. Not a computer user.

Input into OSHPD decisions: Not adequate.

Data from other State agencies: DHS County Data Summaries (which have very little hospital data)

Major use of data: Strategic planning.

Consultant 4

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Publications	no	Web site
Frequency of Use: Often Seldom	Seldom	Never	Frequent
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other	Little need for financial data		
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Revenue by payer, charity and other revenue deductions		All acute care data Would not have problem if on hospital FY basis
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other			• Timeliness • Comprehensiveness. • Problem with transfers
Recommendations for Change			• Definitions should be more explicit and consistent across the three reports • Quicker turnaround • Add demographic data by acute bed category

Data accessibility: Very good.

Input into OSHPD decisions: Hasn't tried, other than discussions with staff.

Data from other State agencies: None

Major use: Planning studies

Consultant 5

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD-ROM		
Frequency of Use: Often Seldom	Often	Seldom	Seldom
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Lack of accuracy	No need
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Most items except payroll and non-acute services		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Uniformity with respect to SB 1255 and SB 855 calculations		
Recommendations for Change	More detail regarding SB 855 and SB 1255		

Data accessibility: Very good.

Input into OSHPD decisions: None, but hasn't tried lately.

Data from other State agencies: None.

Major use: SB 855 calculations

Purchaser 1

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Summary reports	CD-Rom	
Frequency of Use: Often Seldom	Often	Often	
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			Doesn't use because there is no data on Medi-Cal utilization
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Mainly summary data on hard copy reports. Doesn't use detailed data.	Depends on Quarterly Report more than Disclosure Report for utilization data	
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Timeliness Lack of product line costs Bad debts and charity incomplete and inaccurate Reporting of county indigent program revenue inconsistent	Too general, should break out general acute care	
Recommendations for Change	Product line costs and revenues Uniform charity, bad debts and country indigent reporting	General acute cost and revenue Uniform charity, bad debts and country indigent reporting	

Major use of data: Payment negotiations

Data from other State agencies: DHS Licensing, Medi-Cal paid claims, Medi-Cal cost reports

Data accessibility: Very good

Input into OSHPD decisions: Excellent

Purchaser 2

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD-ROM	Internet	No
Frequency of Use: Often Seldom	Often	Not as often as the Annual Disclosure	
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Not detailed enough for purpose used (see below)	
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Cost and Revenue Data. Payer Mix Data based on Revenue. Staffing and Payroll Utilization (Days) CEO Names		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Timeliness--too far behind. Uniformity, accuracy and comprehensiveness pretty good		
Recommendations for Change	A more uniform reporting period. The concern arose not so much from differences in fiscal years as from inclusion in the data of odd (usually short) reporting periods (caused by change in ownership or closure).		

Does not use hospital data from other State sources but does use the American Hospital Association and California Healthcare Association publications.

Access to data: the disclosure data is somewhat difficult to use and requires considerable computer programming. Would prefer data formatted for standard spreadsheet software, *e.g.*, Excel, although he is aware it may not be possible to do this with the entire disclosure database.

(See next page for additional comments)

Purchaser 2 (continued)

Input to OSHPD staff: has tried to get answers to technical questions but could not get to the right person.

Supports product line accounting as long as the product lines are uniformly defined.

Supports alternative utilization statistics if it results in more uniformity.

Supports consolidation of the Medi-Cal and disclosure reports, provided that the current disclosure information is maintained.

Provider 1

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD-ROM		
Frequency of Use: Often Seldom	Often	Never	Never
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		No data on managed care	No data on managed care
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Utilization, revenue by payer, and balance sheet		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	• Timeliness • Comprehensiveness: not enough data by managed care payer		
Recommendations for Change	• More payer specificity • Add discharge data summaries (e.g., case-mix index, outcomes		

Major use: Statewide benchmarking focusing on managed care

Provider 2

`	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	No Not much aware of any of the OSHPD publications	Internet	Internet
Frequency of Use: Often Seldom		Seldom	Often
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Uniformity a problem. Not sure data is comparable across hospitals	Satisfied with timeliness and accuracy; same concerns about uniformity as with quarterly data.
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other			Inpatient Bed Utilization (Discharges, Census Days by Bed Classification) Abortion Stats EMS
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other			Has a hard time with the AHR being split into two files and with the columns headers which are too cryptic. File has no hospital names.
Recommendations for Change			See below

Would like a hospital system code (good suggestion for all reports). Also would like some sort of archives of Internet files (to be able to retrieve older data that may have been missed when originally posted).

Would not have problems if the utilization data were reported by hospital fiscal year instead of calendar.

Provider 3

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
Access Mode: OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD ROM	No	No
Frequency of Use: Often Seldom	Often		
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Page 4 for Pat. Days/Disch & Ancillary Stats Pages 17,18 for Direct Costs (Not Page 10 with the allocated costs) Page 12 for Revenues		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Mild concern with the timeliness; satisfied with the other categories		
Recommendations for Change	Would like to see page 12 deductions from revenue, col 21&23 (All Payers, Inpatient and Outpatient, respectively) reported instead of blanked out (The Medi-Cal contracting confidentiality problem!)		

The unit uses the disclosure data for contracting "off site" for their patients. This covers acute and long-term (SNF) inpatient services, and outpatient services. Develops cost profiles of hospitals, analyzes cost structure relative to charges and looks at variable vs. fixed costs.

Does not currently use data from other state sources (does use Medicare cost reports). Access to data is good. Did not feel the need to provide input to OSHPD staff.

Would like product line reporting if it were introduced gradually and the current functional accounting would also be maintained. Supports consolidation of the Medi-Cal and disclosure reports, provided that the current disclosure information is maintained.

Provider 4

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	Summary file on Web Tape obtained through L.A. County	Web	Tape from L.A. County
Frequency of Use: Often Seldom	Often	Often	Often
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other			
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	All, except staffing and payroll	All	All except patient demographics Consolidation with disclosure report OK
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Accuracy and perception of accuracy, especially for charity, bad debts and medical education. • Not enough data on physicians, surgi-centers and HMOs owned by hospital systems.		
Recommendations for Change	Add a Home Office Report similar to that filed with Medicare, to be able to pick up data on physician groups, HMOs and other health services owned by system.		

Data accessibility: Very good. Likes summary disclosure file on Web, and CD-ROM with entire Disclosure file.

Input into OSHPD decisions: Very good, but attributed to his organization.

Consolidation of Medi-Cal Cost Report in to Disclosure Report OK if doesn't compromise Disclosure Report, or make it harder to work with.

Major use: Membership repository and advocacy

Provider 5

	Report		
	Annual Disclosure	**Quarterly**	**Annual Report**
***Access Mode**:* OSHPD Publications OSHPD Web Site Purchase Tapes /Cartridges/CD-ROM "Raw" Data	CD-ROM	Internet	No
Frequency of Use: Often Seldom	Very Often	Once a year	
If seldom, reason: Timeliness Uniformity Comprehensiveness Accuracy Other		Not much detail	
Data categories most often used: Utilization Pat. Days/Disch Ancillary Stats Cost Revenue Payer-specific Balance Sheet Staffing&Payroll Non-acute Services Other	Uses just about all pages; uses cost center detail. Doesn't use page 3, 6, 7, 10, 14, 19. Uses page 18 units (sq, ft., etc.)		
Specific Problems X above categories: Timeliness Uniformity Accuracy Comprehensiveness Other	Timeliness OK and improving; accuracy good; lack of uniformity inherent in how hospitals report (which cost center they use to report specific services, reclasses, etc.). Very concerned about hospitals missing from tape because didn't fill out in time.		
Recommendations for Change	Would very much want to see managed care broken out separately (which is coming).		

Uses the data for advocacy and benchmarking. Does not use hospital data from any other state source directly. However, does receive Medi-Cal paid claims summary data from a consultant. Does not have significant interaction with OSHPD staff but hospital staff report very good OSHPD response. Supports simplifying the standard units of measure and consolidation of the disclosure and Medi-Cal cost reports. Supports product line reporting but doubts that uniformity could be improved relative to the current system.

PART 6
Approaches in Three Other States

TABLE OF CONTENTS

BACKGROUND

The majority of this report has focused on issues specific to the existing California hospital data reporting system. While the analysis provides a greater understanding of current data reporting issues, concerns and opportunities for improvement, the project would be incomplete if it did not seek to identify ways California can learn from data system improvements achieved by other states. As part of its comprehensive approach, the project team has sought additional opportunities for improvement in the California hospital data reporting system through increasing the understanding of similar data reporting systems in other states.

Several states offer California potentially interesting comparison information on hospital data reporting. Selection of a limited study sample from other states was complicated by various factors. Each state considered had distinct advantages and disadvantages. For example, some states have highly developed structures for hospital data reporting, but their state processes seem inconsistent with resolution of the previously identified issues of concern within the existing California data system. Other states have less sophisticated data reporting systems and were judged to hold low potential learning value for California.

Ultimately, the three states selected, Florida, Massachusetts and Colorado, were deemed to offer the California study a unique cross-section of hospital data reporting from across the nation.

Florida was selected because it provided a hospital data reporting system that appeared to be modeled after the accounting and reporting system required in California. The project team thought that Florida potentially could offer information on how a similar system addressed issues of data submission, collection, and dissemination. Massachusetts was chosen partly because it represents a highly developed hospital data reporting structure. However, the key feature in selecting Massachusetts was its innovative use of the hospital data collected. Finally, Colorado provided a unique combination of innovation in the use of hospital data, as well as an unusual public-private partnership model between state government and the state hospital association.

The California project team conducted on-site, key informant interviews with representatives from each of the three selected states. The interviews focused

on documenting the existing hospital data reporting processes for each state, specific issues of concern the states have with their current systems, and the areas for possible improvement identified within each state's existing data reporting system.

The following section of this report provides a discussion of findings from the states of Florida, Massachusetts and Colorado. The section also provides the recommendations and describes the opportunities for improvement that these states have to offer California.

EXAMINATION OF DATA REPORTING IN FLORIDA

Introduction

Florida has a long history of state financial reporting, and its hospital association and the state Agency for Health Care Administration were open to participating in this project. Financial and utilization reporting in Florida began in 1979. Its hospital data collection activities are a valuable source of information for various purposes—for those who establish health care policies, for Medicaid reimbursement and for assessing the State tax on hospitals to be redistributed for indigent care.

On July 28th and 29th, our project team visited with the Florida Hospital Association and the Agency for Health Care Administration. Our objectives were to determine if there were opportunities for California to consider in the areas of type of hospital data collected, as well as processing and disseminating of information. We will make recommendations in each of these areas based upon what we learned during this visit.

Summary of Hospital Financial/Utilization Data Reporting

The State of Florida web site provides this description of the uniform reporting system:

"Hospital financial data and utilization statistics are reported using a uniform chart of accounts known as the Florida Hospital Uniform Reporting System [FHURS]. The American Hospital Association Chart of Accounts provides the framework for departmental revenues, expenses, hospital gains, losses and deductions from revenue. Revenues, expenses, assets, liabilities and net assets are reported, in most instances, in accordance with generally accepted accounting principles (GAAP). An example of a significant departure from GAAP is found in the reporting of bad debts. Under GAAP, bad debts are classified as an operating expense. In accordance with FHURS, bad debts are reported as a deduction from revenue. The FHURS report has been incorporated by reference into the Florida Administrative Code as Rule 59E-5.102.

"Within 120 days subsequent to the end of the [hospital's] fiscal year, hospitals are required to file their actual financial experience. (Section 408.061 F.S). The actual experience is defined as a prior year report in Rule 59E-5.101 (21) F.A.C. The prior year report must be prepared from hospital financial data audited by a Florida licensed Certified Public Accountant using generally accepted auditing standards and accounting principals…. The auditor's report must contain an opinion. An audit report containing a disclaimer of opinion disqualifies the acceptance process…. Any differences between the FHURS report and the audited financial statements must be reconciled and/or explained. The applicable Medicare Cost Report is required to be filed with the FHURS report.

"The Agency has 90 days to conduct an initial review of the prior year report…. The report is reviewed to determine whether it is complete, conforming, and verified…. The report is deemed complete if al forms, documentation and the auditor's report, with an opinion, have been received. The report is deemed conforming if it has been prepared in accordance with the FHURS requirements and GAAP. The report is deemed verified when the financial data mathematically accurate, reasonable and supported."

The data elements reported in the FHURS include the following categories:

- Hospital name, address, license number, telephone, reporting period, and certification by both the CEO and CFO of the hospital as to the accuracy of the data reported.
- Provider numbers for Title V, Medicare and Medicaid.
- Preparer's name, title and telephone number.
- Hospital general information, *e.g.,* type of control, type of hospital and type of management.
- Statistics on bone marrow transplants, open-heart cases, heart transplants, kidney transplants, liver transplants, lung transplants, neurosurgery cases and radiation therapy cancer cases.
- Statistics for patient care departments. Included are applicable days (patient units), patient weeks (dialysis), minutes (surgery), trips (ambulance), visits (ER and clinics), workload units (lab) and procedures (other ancillary departments).
- Licensed beds, available beds (at end of period and total) and total patient days by unit.
- Acute and sub-acute days and admissions by payer.
- Analysis of changes in property, plant and equipment.
- Medical staff count and FTE's by department and broken down by medical student, resident or active staff.
- Allied health education student count by program.
- Balance Sheet by fund.
- Summary Income Statement including gross charges, deductions from revenue, expenses and other gains and losses.
- Inpatient and outpatient revenue by department.
- Contractual deductions by payer and bad debts.
- A breakout of other operating and non-operating revenue.
- Expenses by department split by Salaries, Other and Total.
- FTE's paid by department.
- Disclosure of costs from related organizations.

- Detailed disclosure of interest expense and debt.
- Allocation statistics including square feet, cost of supplies, pounds of laundry, number household, nursing FTE's, central supply costed requisitions, pharmacy costed requisitions, and graduate medical education assigned time.
- Employee benefits broken down by category.
- Research and education revenue and expenses.
- Schedule of capital expenditures.
- Statement of patient rates and discount policies.
- Disclosure of number of prospective payment contracts including volume of admissions.
- Name and address of each health insurer that has a prospective payment arrangement with the hospital.
- Psychiatric hospital statistics broken down by specialty.

The Florida Agency for Health Care Administration (AHCA), Office of Medicaid Cost Reimbursement Planning and Analysis, also requires the following supplemental data be submitted with the Medicare cost report (HCFA-2552) on an annual basis:

- Disproportionate share program key components including:
    1. Medicaid days excluding concurrent nursery days.
    2. Total patient acute and intensive care days.
    3. Charity/uncompensated care, total and broken down between inpatient and outpatient.
    4. Total inpatient revenue, sub-acute inpatient revenue, total patient revenue and other operating revenue.
    5. Government or tax districts unrestricted tax revenue and appropriated funds, and restricted donations and grants for indigent care.
- Medicaid nursery day information for non-concurrent, concurrent and total days.
- The indigent care assessment amount.

Hospital Association's Perspective

On July 28, 1999 the project team met with Kim Strait of the Florida Hospital Association (FHA) to discuss her perceptions of the hospital financial/utilization data reporting process. Ms. Strait has been using the FHURS data since 1986. The FHA is concerned the financial/utilization data reporting process may be in jeopardy of being eliminated. The State review of hospital budgets has been repealed, and the future of the Certificate of Need (CON) program is in doubt under the new Administration.

FHA recently requested 235 of Florida's 260 hospitals to voluntarily supply miscellaneous data to them directly. The association received only 35 responses to its request. This lack of response increases FHA's concern over the possible elimination of FHURS.

FHA produces general and custom reports for its membership and uses the data for advocacy purposes. FHA only utilizes about half of the data submitted; focusing on financial/utilization data that is supplied in an electronic format and is common to all hospitals.

FHA would like to see contract labor information added to the FHURS report. It also believes the ability of hospitals with multiple locations under one license to consolidate the information submitted reduces the quality of the data for analysis by location.

Another concern of FHA is how hospitals change their hospital structure to decrease their exposure to the indigent care tax. The 1½ percent tax is levied based upon hospital net revenue. If hospitals change their organizations so outpatient departments become "freestanding" units, the net revenue from these departments is no longer taxed. FHA is concerned that this trend in reorganization is corrupting the comparability of the FHURS data.

The State Agency's Perspective

On July 29, 1999 the project team met with Christopher Augsburger, Regulatory Analyst Supervisor, from the Agency for Health Care Administration (AHCA) that receives and audits the FHURS report. The Agency noted that the budget review process was repealed July 1, 1999.

The agency has three staff devoted to reviewing the FHURS reports submitted. The agency stated that "very rarely" are the FHURS submissions correct the first time. If errors are found, the reports are returned to the hospitals for corrections. The agency also receives a copy of the Medicare cost report (HCFA 2552)

and a one-page supplemental form. (See the description data on the supplemental Medicaid form under the section titled Summary of Hospital Financial/Utilization Data Reporting, above.)

The agency had considered replacing the FHURS report with the Medicare cost report plus expanded supplemental forms. It decided against such a change based upon public disclosure concerns and allocation statistics concerns.

The data are available to each hospital free of charge. Others can purchase the data and received it in an electronic computer disk format.

User's Perspective

The Florida Hospital Association was the only data user interviewed because there were no opportunities for California found in the FHURS system. The major uses of the FHURS data have been for Certificate of Need (CON) and State budget review. The State budget review has been repealed, and the future of CON is in doubt under the new Administration. Even the future of the financial reporting system is not secure. When the budget review program was operative, the reporting system included budget data corresponding to each historical data element. Now, only historical data are reported.

Other than for the two purposes set forth above, the major data user is the Florida Hospital Association, which produces general and custom reports for its membership and uses the data for advocacy purposes. The media is also a data user. Finally, the Agency for Health Care Administration (which administers the reporting system and Medicaid) publishes summary reports.

A major problem affecting the comprehensiveness of reporting is that the Medicaid program is partially supported by a net revenue tax on hospitals. This provides an incentive to move some hospital-sponsored services to related organizations; these programs' data are not reported. Another problem is the ability of hospitals to consolidate licenses across the state and report as one entity (about 50 hospitals were dropped from reporting due to licensure consolidation).

There are autonomous local health councils that are involved in health planning. They also gather hospital data, some of which may duplicate the AHCA data. To our knowledge, there have been no efforts to identify the degree of duplication.

Opportunities for California

Because the reporting system is similar to California's, although slightly less detailed, there are no perceived opportunities for California in the Florida reporting system. One aspect of the Florida reporting system evaluated elsewhere in this report is the uniform definition of charity care, based upon federal poverty standards. See the separate section of this report for the discussion and recommendation.

EXAMINATION OF DATA REPORTING IN MASSACHUSETTS

Introduction

Massachusetts has been a recognized leader in the health care financial policy arena for a number of years. Its hospital data collection activities are a valuable source of information for various purposes. These include providing data for those who establish health care policies, pricing and reimbursement rates. In addition, the data are used in the administration of an uncompensated care pool that reimburses hospitals for services provided to the uninsured and underinsured. Understanding how hospital data are utilized for various innovative programs was the basis for the selection of Massachusetts in this study.

On August 18 and 19, 1999, our project team visited with the Massachusetts Hospital Association (MHA) and the Division of Health Care Finance and Policy (DHCFP) of the Commonwealth of Massachusetts. Our objectives were to determine if there were opportunities for California to consider in the areas of type of hospital data collected, as well as processing and disseminating the information. We will make specific recommendations in each of these areas based upon what we learned during these visits.

Summary of Hospital Financial/Utilization Data Reporting

On July 1, 1996, DHCFP replaced the Massachusetts Rate Setting Commission with the following goals and objectives as outlined by its Mission Statement.

> *"To contribute to the development of policies that improve the delivery and financing of health care in Massachusetts by:*
>
> *"Collecting and analyzing data from throughout the health care delivery system;*

"Disseminating accurate information and analysis on a timely basis;

"Facilitating the use of information among health care purchasers, providers, consumers and policy makers; and;

"Monitoring free care in the commonwealth through thoughtful administration of the Uncompensated Care Pool."

DHCFP requires every Massachusetts acute care hospital (and non-acute e.g., chronic/rehabilitation, psychiatric hospital) to submit the DHCFP-403 reporting form each fiscal year. The report is due 120 days after the hospital's fiscal year. Extensions, requested either before or after the due date, are permitted. Most hospitals receive extensions; however, the attorney general's office does have the authority to levy $1,000 a day penalties for late filings. In addition, the hospital's Medicaid rate can be reduced for either failure to file or late filing.

All acute care hospitals, except municipally operated hospitals, are required to file a complete fiscal year's worth of information for the period ending on September 30th. If hospitals operate under a different fiscal year, such as some that are part of a national chain, they would still be required to file based upon a September 30th fiscal year end. Municipally operated hospitals file based upon a June 30th fiscal year end.

The DHCFP-403 is modeled after the Medicare cost report Form 2552, and is very similar to California's OSHPD annual disclosure report. The following is a summary of the type of data contained in the report as described in the reporting instructions:

- Total expenses by overhead, ancillary and routine department.
- Departmental expenses breakouts by salaries and wages, physician compensation, purchased services, supplies and expenses, and major movable equipment depreciation.
- Gross revenues by ancillary and routine department.
- Statistics by overhead and ancillary department.
- Gross and net patient service revenues by payer.
- Inpatient and outpatient statistics by payer.

Some of the information included in the above categories differs from the data required in California by OSHPD as follows:

- Patient days are required by month.
- Payroll information is limited to FTEs by employee classification.
- Payer categories are specifically defined in the instructions with the names of all payers identified. Workers compensation is separately identified. Managed care categories have been broken out for Medicare, Medicaid and other insurance as they are now in California.
- Gross patient revenue is reported by each routine and ambulatory service cost center, incorporating the ancillary services. To capture this data, hospitals are required to maintain ledgers that allow them to classify the ancillary revenues in this manner.
- Free care funds received by the hospital are identified.
- Gross operating expenses by department, by natural classification, are reported with and without capital. In addition, a second step-down allocation is applied that allocates the total ancillary costs (direct and indirect) to the routine and ambulatory cost centers. This is accomplished by applying ancillary department standard units of measure as allocation statistics.
- The total revenues and total expenses identified on the above schedules must be reconciled with the revenues and expenses on the audited financial statements through the use of specific worksheets.
- Revenue deductions are broken out by payer category for total revenues; they are also broken out for inpatient and outpatient, but not by payer category.
- Standardized financial statements, similar to those filed in California with OSHPD, are required. However, these are also reconciled with the audited financial statements. In addition, financial ratios are calculated and shown on the standardized financial statement worksheets.
- Audited financial statements must be submitted along with the DHCFP-403, and must cover the same fiscal year end as the reporting forms.

DHCFP receives $10 million annually to fund its data collection, processing and disseminating activities. The funding comes from an assessment of hospitals based upon a percentage of their revenues. For the first time, a portion of the funding ($3.7 million) has been received through Federal Financial Participation (FFP) to fund activities related to the Medicaid program; previously all fund-

ing was obtained from Blue Cross. The goal of DHCFP is to receive 50 percent of funding from hospitals, and the remainder from revenue generating projects.

The State Agency Perspective

On August 19, 1999 the project team met with representatives from the DHCFP to discuss their role in the hospital financial/utilization data reporting process. Representatives from DHCFP included:

- Louis I. Freedman, Acting Commissioner
- Gerald F. O'Keefe, Health Data Policy Group Director
- Diane McKenzie, 403 Cost Report Database Manager
- Steve McCabe, Pricing Director
- Michael Grenier, Analyst
- Mary Byrnes, Pricing Manager
- Michael Berolinie, Audit, Compliance, and Evaluation Director

DHCFP, which is one of 18 departments in the Department of Health & Human Services, is comprised of the following:

- Health Data Policy Group, whose function is to manage the databases, including the financial reporting forms.
- Audit, Compliance and Evaluation Group, whose function is to validate the financial and utilization reports, and to validate the data being utilized in the Uncompensated Care Pool.
- Health Systems Measurement and Improvement Group, whose function is to provide data research.
- Pricing Policy and Financial Analysis Group, whose function is manage rate regulatory activities, and to manage the uncompensated care pool.
- Other support groups include Legal, Communications, Information Technology and Administration.

DHCFP has a $10 million budget, with a staff of one hundred and thirty individuals. Although the DHCFP reports directly to the executive branch, it is viewed as the health care analysis "arm" of the legislature. Even though timeliness of information is important, accuracy and open communication are stressed by DHCFP.

***Health Data Policy Group**:* This group is responsible for managing, developing and disseminating health care information obtained from the DHCFP-403 cost report and the hospital discharge databases. They manage the overall process of the DHCFP-403 report from intake to preparation of databases for internal and external use, maintain and update the DHCFP-403 reporting forms, identify policy issues where the data can inform, and prepare related publications that utilize this information.

Although the DHCFP-403 reporting forms have changed annually since 1993, most of the basic information remains the same. Administrative changes, such as reporting interpretations or modifications to the reporting forms that do not change the basic concept of the data that is being reported, can be made by issuing bulletins. Significant changes, such as those that modify the basic reporting principles by altering an accounting concept or adding a substantial amount of new information, need a regulatory change. It should be noted that DHCFP does have the authority to collect data quarterly, but has not chosen to do so at this time.

Audit, Compliance and Evaluation Group: The DHCFP-403 reporting form is submitted to a desk review process only. The desk review process is prioritized based upon various criteria and needs during the fiscal year. For example, this year's priorities are reports needed to set Medicaid payment rates, and reports filed by "financially distressed hospitals."

Desk reviews for the priority hospitals are usually completed by June 1st, while the remaining hospital reviews are completed between July and August. It is important to note that most hospital reports were due by January 31st. The reviewed data are usually available for distribution between six to nine months later. The typical desk review takes about five days to complete, including ongoing communication between the hospital and DHCFP. Overall each hospital's report is completed in about three weeks from the date that work is begun. Usually the desk reviewer works on multiple hospital reports at once. In most cases there are adjustments to some of the data contained in the filed versions of the report. The hospital is given 10 days to respond to adjustments. The actual adjustments are available to the public under the Freedom of Information Act.

DHCFP-403s are submitted on both hard copy and diskette, and one consistent problem is a difficulty in matching the two. A significant amount of time is spent reconciling the two source documents. Hospitals are also required to submit their audited financial statements and a vendor edit checklist, along with the actual report. The audited financial statements are very useful because they provide valuable information about the hospital's operations in the notes to the

financial statements. The vendor edit checklist is very useful because it lists areas where the report is inconsistent or data is absent, and because it allows the hospital to explain why variances exist or why edits cannot be corrected. This saves significant time during the desk review. These two documents might be considered for improving the OSHPD desk review process in California.

Field audits are only used to ensure hospitals are complying with regulations on Uncompensated Care Pool data reporting. DHCFP does not see the need for a field audit of data used only for disclosure purposes.

Health Systems Measurement and Improvement Group: This group is an internal data user that provides health services research and policy analysis for various outside users of the DHCFP data. Its purpose is to improve health care services for the uninsured and underinsured in an effort to reduce the demand on the Uncompensated Care Pool. It uses the DHCFP-403 information for various research reports to health care policy makers, health care providers and health care purchasers so they can make more informed decisions on the health care needs.

Pricing Policy and Financial Analysis Group*:* This group develops health care pricing materials focusing on care of public beneficiaries, primarily those related to the Medicaid program. They provide information, analysis and recommendations to policy makers responsible for health care financing decisions. The group also manages Massachusetts' free care pool.

For regulatory purposes, this group uses the DHCFP-403 to calculate the cost-to-charge ratio that determines the Uncompensated Care Pool (Free Care Pool) payments, which are used by the Department of Medical Assistance for Medicaid purposes, and also used to establish Workers Compensation rates.

The Pricing Policy and Financial Analysis Group requires all hospitals to submit their written charity (free care) policies for review and approval to verify that they meet regulations. Patients with family income up to 200 percent of the Federal Poverty Income Guidelines are eligible for full free care, while those with family incomes between 201 % and 400 percent of the Guidelines are eligible for partial free care.

Funding for the Pool comes from three sources. Acute care hospitals are assessed a percentage of their private sector gross charges ($215 million). A surcharge is assessed on payments made to hospital and ambulatory surgical centers by HMOs, insurers and individual payers ($100 million). An additional $30 million is added from the Commonwealth's general fund. In addition, $70 million

per year has been added in federal funds for free care provided to two specific hospitals.

The Hospital Perspective

On August 18, 1999 the project team met with representatives from the Massachusetts Hospital Association (MHA) to discuss their views on the hospital financial/utilization data reporting required of hospitals. Representatives from MHA included:

- James T. Kirkpatrick, Vice President, Health Care Finance and Managed Care Advocacy
- Robert E. Mechanic, Senior Vice President, Health Care Economics
- David P. Smith, Senior Director

The MHA emphasized that the Commonwealth has moved to a less regulatory environment by eliminating rate setting, except for Medicaid and Worker's Compensation. Most information used by MHA or its members is not from the DHCFP-403, but patient discharge information. Except for calculating payments for the Uncompensated Care Pool, MHA does not find information collected on the DHCFP-403 to be very useful. In fact, to collect more useable and timely data, MHA has begun collecting quarterly financial and utilization on a voluntary basis from its members. It should be noted, however, that DHCFP did indicate that MHA does purchase their data on an annual basis, and makes requests for selected data from the DHCFP-403.

MHA indicated that the members do not support the reporting requirement or assessment required to pay for collecting data on the DHCFP-403. They believe that payers are the major data users and should, therefore, pay for service. If insurers use the financial and utilization information then the insurance companies' databases should be linked to obtain the required information, instead of having hospitals provide the data directly.

MHA members believe that the DHCFP-430 should be more standardized and less burdensome, or even be replaced by the Medicare cost report. They did indicate that hospitals are given an opportunity to provide input into the data collection requirements; however, neither MHA nor its members have the time to be involved in the process. Crises related to government reimbursement reductions have taken priority over data reporting issues.

The Data User Perspective

In addition to the two data users that were interviewed, staff at DHCFP has indicated that public payers utilize the data in pricing policy and program design. In addition, DHCFP has provided us with the following examples of how the data are being used by various external data users:

- *Local media:* utilization statistics, financial indicators for local hospitals.
- *Researchers:* free care data, cost-to-charge ratios; financial analysis; bed data used for research, journal articles and legislative testimony.
- *Private payers:* cost information for negotiations with hospitals or calculating reimbursement rates.
- *Legislators:* statistics for hospitals in their communities; information related to policy issues or proposed bills.
- *Hospitals:* statistics and financial indicators for competitors; benchmarking; negotiation with payers.
- *Consulting firms:* provide information on competitors to hospital clients; provide databases on hospital-specific DRG costs.
- *Hospital Association:* financial analysis of industry; to simulate the effects on hospitals of changes in reimbursement policy.
- *HMO Association:* financial analysis of industry.
- *Administration:* information on all or selected hospitals related to policy issues.

DHCFP referred us to four private-sector data users in Massachusetts. Two responded to our request to be interviewed. They were questioned regarding the following:

- Their satisfaction with the data
- The timeliness of the data
- Their input into the data collection and reporting process
- Their use of two major data categories that are not part of the OSHPD uniform reporting system — product line costs and revenues, and patient days reported on a monthly basis

Marie McIntyre, Financial Analyst, Bay State Health System. She is satisfied with the data and the access procedure. The entire file can be received

electronically (there are about 80 hospitals in the State). The file includes titles for each variable, unlike OSHPD. The timeliness is probably as good as it can be; there is a 13-month turnaround from the close of the reporting period, to the availability of the entire data set (all hospitals are on the same reporting period). Input is good; she is queried by the Agency, and the latter is responsive. She does not use the product-line costs or the monthly patient day counts. She is concerned that the departmental-level data are not accurate, as the smaller hospitals are not allocating costs correctly (since they generally do not hire accounting firms to prepare the reports). Thus, she feels the product-line data are not accurate for these hospitals. Given these concerns, she mostly uses the report to make financial comparisons between hospitals as a whole (e.g., balance sheet, income statement).

Nancy Kane, Finance Professor, Harvard University. She is generally satisfied with timeliness, access and input. She does not use the product-line data or the monthly patient days data. She only looks at the financial statements, but not because of issues surrounding the accuracy of the data; she is a financial analyst and is only concerned about these specific aspects.

Opportunities for California

After evaluating the hospital uniform data reporting requirements in Massachusetts, we believe the opportunities for California fall into three categories. They include specific data reporting elements, the focus and mission of the data collecting/processing agency, and the Uncompensated Care Pool.

As outlined earlier in the data reporting requirements summary, there are some differences between the uniform reports in California and Massachusetts. Of those that were identified, we believe a few warrant consideration in California. Specifically, and most important, is the allocation of the ancillary departmental costs (after overhead allocation) to the routine and ambulatory departments. This would allow the data user to measure the total costs incurred by these departments; this is not possible with the OSHPD report. From a reporting standpoint, it would require the hospitals to identify the specific routine and ambulatory departments using ancillary services by reporting the current ancillary standard units of measure in the appropriate departments. OSHPD could then automatically generate a “step-down” of these costs into the appropriate departments.

Depending upon the need to continue reporting payroll information, OSHPD may want to consider simplifying the data being reported. Hospital interviews in California indicate the payroll data is one of the most burdensome accounting

and reporting requirements. Massachusetts requires only the reporting of FTEs by employee classification. This approach may offer an adequate level of reporting, and would simplify the reporting requirements.

In addition to filing the uniform report, Massachusetts hospitals are required to submit a copy of their audited financial statements. DHCFP has indicated that the notes to the audited financial statements are very useful in understanding the data a hospital is reporting. For several reasons this may be useful for California to consider. First, Medicare and Medi-Cal already require these statements, so this would not be an additional reporting burden. Second, depending upon whether OSHPD's mission and focus is modified, the information contained in the notes to the statements will assist with any analysis that is performed. Third, based upon the interviews with the hospitals, the current need to modify a hospital's existing financial statements into the OSHPD formats is extremely burdensome, and leads to inaccurate reporting. Perhaps some of the financial statements could be eliminated from the OSHPD reporting requirements (e.g. cash flow statement), and a copy of the audited financial statements provided to the data user along with the uniform report. DHCFP, however, still requires that standardized financial statements be submitted as part of the DHCFP-403 report. They require these schedules, in addition to the audited financial statements because hospital financial statements are not standardized across line items. This would make it difficult to analyze financial data from the audited reports because of a lack of comparability.

The DHCFP-403 collects patient days on a monthly basis. If average licensed beds were also collected monthly, a monthly occupancy rate could be calculated. This would enable the data user to analyze seasonal variations, and identify whether there are periods in which bed shortages are occurring.

As described earlier, DHCFP's role in the health care policy arena is more than just a data bank. In addition to collecting and disseminating hospital financial and utilization data, DHCFP analyzes the information and prepares research reports that address health policy issues. Its focus appears to be the preservation of quality health care in communities by providing research that is valuable to not only legislators and administration, but also to providers and consumers. There appear to be three types of research reports that are prepared and disseminated regularly, or as important issues come to the forefront. They include:

- *Monitoring Reports:* These reports monitor the state of the acute hospital industry and examine trends in hospital utilization, efficiency and financial health.

- *Healthpoint*: Research reports that update health care trends of general interest and address issues of current importance to policy makers in Massachusetts.
- *Datapoint*: A quarterly publication that summarizes the most current data collected by DHCFP.
- *In-Depth special reports*: Research papers focusing on selected topics.

Examples of some of the reports are included in the appendix, along with a listing of all publications currently available. Some of the topics are very policy-relevant in Massachusetts and have included:

- "Your Guide to Managed Care in Massachusetts"
- "Health Insurance Status of Massachusetts Residents"
- "HMO Rate Analysis: 1997 Spending, Unit Cost and Utilization"
- "The Impact of Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers and Medicaid"
- "Case Mix Payer Validation Report"

We believe that OSHPD's role should be evaluated in light of the current health care policy arena. The former California Health Facilities Commission, in addition to collecting data, focused on whether hospital costs should be controlled through rate setting or budget control. This led to an adversarial relationship between the provider community and the Commission, and the eventual demise of the Commission. Since then, OSHPD has limited its role to that of a data bank. Based on what we have seen in Massachusetts, much can be gained if OSHPD's were to expand its role to provide the necessary data and research to aid in the preservation the health care in all communities in California.

A final opportunity that California may want to explore further is establishing an uncompensated care pool to pay hospitals for patients unable to pay for their health care. The system established in Massachusetts appears to be operating very successfully, and is beginning to create reserves. Hospitals are compensated fairly for the free care they provide. In addition, it is not a system that merely redistributes hospital dollars. Others who have a stake in health care are also responsible for funding the program. In light of the current funding for indigent care in California under both the tobacco tax programs and disproportionate share programs, and the concerns over how charity care should be measured and accounted for, this type of uncompensated care program provides an op-

portunity for California to better address hospital payment shortfalls that occur in meeting the health care needs of their communities.

EXAMINATION OF DATA REPORTING IN COLORADO

Introduction

Colorado was selected as one of the three comparison states because of the Colorado Hospital Association's "DATABANK" program. Since the American Hospital Association discontinued its national financial and statistical data bank service, Colorado has tried to become the national database for financial and statistical data. Currently, 30 states participate in the DATABANK program. DATABANK focuses on operational data (income statement) but also gathers utilization and some balance sheet items. The data is submitted monthly. After submission, reports are generated which contain numerous operational indicators for hospitals and for peer groups that combine hospitals with similar operational characteristics. The Colorado Department of Health obtains the data it uses from the Colorado Hospital Association (CoHA). The possibility for national benchmarking of California hospital data is the reason Colorado was selected.

On September 10, 1999, our project team visited with the CoHA. Because it is the only source of this data in the state no other agencies were visited. Our objectives were to determine if there were opportunities for California to consider in the areas of type of hospital data collected, as well as processing and disseminating information. We will make recommendations in each of these areas based upon what we learned during this visit.

Summary of Hospital Financial/Utilization Data Reporting

The Colorado Department of Health requires all hospitals that participate in Medicaid to participate in both the DATABANK program and the CoHA Discharge Data system. These are the sources for all the information it needs, so hospitals are not required to submit financial data directly to the Department.

The data for the monthly input consist of both utilization and financial data. There are two pages of input information. CoHA believes "the data elements reported are those items that are routinely collected and used in a hospital's inter-

nal financial statements." CoHA estimates the time to complete the input at 50 minutes. The following is a list of data supplied by hospitals:

- Hospital name, identification number, month, year, available beds and licensed beds.
- Discharges and patient days for the period, broken down by Medicare, Medicaid, Self-Pay, three optional payer categories, and Other. Also broken down by Acute Care, Swing Bed, Sub-acute/LTC, and DPU (distinct part units).
- Total inpatient surgeries.
- Total births.
- Total newborn patient days.
- Total admissions from the Emergency Department.
- Total Emergency Department visits.
- Total Ambulatory Surgery visits.
- Total Observation visits.
- Total Home Health visits.
- All other visits.
- Total Outpatient Visits.
- Charges for the period broken down between Medicare, Medicaid, Self-Pay, three optional payer categories, and Other. Also broken down by Acute Care Inpatient, Acute Care Outpatient, Swing Bed, Sub-acute/LTC, DPU and Home Health.
- Contractual Allowances for the period broken down between Medicare, Medicaid, Self-Pay, three optional payer categories and Other. Also broken down by Acute and Other.
- Total Charity Care.
- Payroll expenses and hours broken down by Facility and Physician.
- Other operating expenses broken down into Benefits, Supply, Depreciation, Interest, Bad Debt, and All Other.
- Other Operating Revenue.
- Net Non-operating Gains.

- Tax Subsidies.
- Gross Patient Accounts Receivable broken down by Medicare, Medicaid, Self-Pay, three optional payer categories, and Other.
- A section for typing in comments.

Data submissions are due the 25th day of the month following the reporting month. The primary method of submitting monthly data is via the Internet DATABANK web site. As an alternative hospitals are allowed to fax manual DATABANK input sheets into the hospital association. Only two of the 30 states participating in the program complete the DATABANK input on a quarterly rather than a monthly basis. The CoHA recommends hospitals complete the input monthly for the following five reasons:

- Hospitals get into the routine of completing the forms.
- The quality of the data input is better due to a shorter time frame.
- The data is never more than 30-35 days old.
- Monthly reports provide immediate feedback to the facility.
- It is easier for the hospital to submit data monthly than to accumulate the same monthly data on a quarterly basis.

Operating the DATABANK program in Colorado consumes one and one-third full time equivalent employees and miscellaneous cost equaling approximately a $100,000 budget. Monthly questions from 60 hospitals take approximately three hours of staff time.

Hospital Association's Perspective

As mentioned in the introduction, the Colorado Hospital Association is in charge of collecting the hospital financial and utilization data for state agencies in Colorado. We met with Peter Freytag, Vice President of Finance, and Kevin Reed, who are in charge of the DATABANK program at the hospital association on September 10, 1999 in Denver.

The CoHA DATABANK program was established in 1985 in response to Colorado hospitals' need for timely information that wasn't a burden to collect. The DATABANK is a financial and utilization database. CoHA uses information from the database for advocacy of member hospitals along with providing useful information to the hospitals that participate. The CoHA identifies timeliness, accuracy, completeness, simplicity and uniformity as other major principles governing the program.

The CoHA allows other states to obtain a license to participate in the DATABANK program. The licensing fee for 1999 was $5,000. As of May 11, 1999 there were 19 states licensed to participate in the DATABANK program. By the September 10th meeting, 30 states were either licensed or committed to join the program. Although three-fifths of the states in the nation are committed to participating, the "tier one" (large) states have not joined. The tier one states include California, Florida, New York, Illinois, Massachusetts, and Pennsylvania. Three of the tier one states (California, Florida, and Massachusetts) are involved in the OSHPD project and have expressed interest in the evaluation of the Colorado DATABANK program.

DATABANK submission is coordinated through the hospital's state association. If California were to join the DATABANK program, the California Healthcare Association would be the primary contact with the CoHA. The requirement for monthly submissions of data, the data elements that are submitted and the method of submission has been explained in the previous section. Also mentioned previously, operating the DATABANK program in Colorado consumes one and one-third full time equivalent employees. California would need more resources due to the quantity of hospitals in the state. The primary employee involved at the state association is assigned the title "Administrator."

As hospitals enter the data on the DATABANK web site, they are presented with validation that the data is reasonable and correct, in light of submissions in previous months. The DATABANK system gives the primary responsibility for accurate reporting to the hospital. After the data are input, the DATABANK system generates a "Monthly Edit/Review Report." The report instructs the hospital to "review this data monthly" and "correct data as needed using the DATABANK web site." This report presents the current month's data input compared with the prior month's data and calculates the percentage difference. See the appendix for a sample of the edit report.

The "Administrator" of the program at the hospital association also reviews this edit report for completeness, accuracy of data input, general reasonableness and accounting sense. If questions or obvious errors are found the "Administrator" contacts the hospital for clarification or correction. Corrections to the hospital data can be made anytime during the calendar year to any previous month's report. If corrections involve multiple months, it is preferred that the hospital applies the corrections to the specific months rather than the latest month.

After the hospital data have been input, a hospital can immediately access all reports that display its data. Reports that include peer group comparisons become available after a minimum number of peer hospitals have submitted data.

The requirement for a minimum number of peer hospitals is made to not allow specific hospitals to be identified. All reports are available through an Internet download or paper copy. The following are the types of reports available:

Monthly Report. This report displays hospital and selected peer group data. The report is either on a current month or a year-to-date format. The peer group can be based on the following criteria: statewide data, Medicare Payment Methodology (large urban, urban or rural), geographic location, operating expense range and bed size. The data are presented both in amount and calculated indicators (e.g. percentages, amounts per day or stay, and other ratios). The year-to-date report is only available if all months included in the report have been submitted by the hospital.

Comparative Report. This report displays either the current and prior year quarterly or year-to-date data. The data are presented in the same format as the monthly report.

Trend Report. This report displays up to 12 periods of the hospital's data and ratios, side by side. The periods can be selected by the hospital (*e.g.,* monthly, quarterly, etc.). The data are in the same format as the monthly report.

***Ad Hoc Reports*.** Hospitals may request that an ad hoc report be generated. Ad hoc reports include comparisons with peer groups not on the monthly comparative reports, or reports based on the hospital's fiscal year rather than a calendar year.

Free access to the reports is limited to the participating hospitals and state hospital associations. Other data users can purchase the reports. Purchasers of data in Colorado have included Medicaid, the Public Health Department, all large insurance groups in the state, advocacy groups, other state hospital associations and an individual hospital in Nebraska. In addition, the full report is periodically disseminated to public libraries.

Finally, the CoHA sponsors an annual DATABANK users group meeting. This meeting is used to hear ideas about modifications to the DATABANK program. However, final decisions about program changes for the basic, core system are up to CoHA.

Hospital's Perspective

Telephone interviews were held with two Colorado hospitals on October 18, 1999. We interviewed a controller of an urban hospital, and a chief financial officer of a rural hospital.

Both hospitals have participated in the DATABANK program for a number of years. Their estimated time needed to input the data varied widely. The urban hospital estimated the time at two to three hours to prepare the monthly input. The rural hospital on the other hand estimated the time at five minutes because all of the input data was taken from the monthly Board report. The rural hospital noted the availability of an Internet web site for inputting data was "fabulous." Both hospitals like the simplicity of the DATABANK input.

Both hospitals analyzed the data monthly. Both hospitals agreed that the year-to-date comparisons were more useful for analysis; monthly data could vary widely. The rural hospital uses all of the data for comparisons. The urban hospital focuses on revenue by discharge; that the local media publishes comparative data and it wants to be prepared to respond to the public publication. The hospital also analyzes salaries, contractuals, and the expenses broken down by natural class.

Neither hospital has recently taken advantage of the annual user meetings that would allow them to suggest modifications of the program.

The hospitals did not voice any issues, concerns or recommendations when asked. However, it should be noted that the urban hospital was very sensitive to the annual data published by the local media. The hospital was not concerned that the data were incorrect or unimportant, but that it be able to explain variances from the peer group when asked.

User's Perspective

Telephone interviews were held with two Colorado DATABANK users on October 18, 1999: a contract negotiator at Blue Cross Blue Shield of Colorado, and a rate setter at the Colorado Department of Health Care Policy and Financing.

The main source of information for both users was the Annual Reference Guide. Both received this guide in hardcopy format rather than electronically. Neither has been using the monthly data. Blue Cross Blue Shield did say that year-to-date quarterly data would be helpful to track pricing trends by area of the state. Neither user has obtained other states' data from the CoHA.

Blue Cross Blue Shield analyzes several data elements: First, the hospital's bed size to patient day data to determine overall hospital utilization. Next, total cost to charge ratios, charges per day and per visit (other payer category) and average length of stay for contracting purposes. Finally, Medicare outpatient contractual percentage of revenue for out-of-network payment benchmarks on Medicare risk contracts.

The user at the Department of Health Care Policy and Financing uses the data for disproportionate share data and bad debts. The key data analyzed include days related to Medicaid HMO, Medicaid Regular and Total, further broken down between newborn and adults and pediatrics. Also reviewed were total bad debts.

Both users have open communications with the CoHA about the DATABANK program. However, neither has been asked or given input into what data should be included in the report.

Both users considered the timeliness of the data an issue. The reference guide they use for their data analysis was issued 12 months after the calendar year end for the 1997 data and is expected to be issued in November of this year for the 1998 data. These publications are not timely enough for the users. The years preceding 1997 were published in July. It is the perception of one of the users that the delay has coincided with the additions of other states to the DATABANK program. Also, Blue Cross Blue Shield misses the case mix index data that was formerly included in the report.

Opportunities for California

The major opportunity for California joining the DATABANK program is to have national rather than statewide benchmarking and trend data. The other significant advantage of DATABANK is availability of comparative data within 35 days of month end. If the quarterly OSHPD report takes eight hours to prepare and the monthly DATABANK report takes 50 minutes to prepare, hospitals will actually save time with monthly reporting. Finally the DATABANK program appears easy for state associations to maintain.

Drawbacks to the DATABANK program include convincing California hospitals that there is an advantage to monthly reporting and not an additional reporting burden. The CoHA must approve all changes to data submitted and reports. This modification limitation may not be too different than the current requirement that the quarterly OSHPD report is required to be changed through legislation. Historical data comparisons would be limited to the amount of back-loaded data that is input into the system.